

THE PROCESSES OF HELP-SEEKING AND COUNSELLOR DEVELOPMENT IN THE  
CONTEXT OF MEN WHO EXPERIENCE INTIMATE PARTNER ABUSE

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By

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## ABSTRACT

Men experience IPA from women at significant rates; this abuse can be severe and can have serious, deleterious effects on men's emotional and physical health. Yet, men are hesitant to seek help for this abuse. Simultaneously, literature depicts a divide amongst counsellors' willingness and ability to provide services to this population. Through a review of this literature, I thought it beneficial to better understand the processes involved in men seeking help in the context of IPA, and in becoming a service provider who validates men's experiences of IPA and is willing to provide counselling to them. To approach this goal, I utilized grounded theory methodology, within the context of a social constructionist epistemology and a relativist ontology. Further, I utilized feminist anti-oppressive theory as my overarching theoretical lens through which I developed and implemented this dissertation project.

Study 1 involved interviews with 10 men who had experienced IPA: eight of whom had sought help, and two of whom had not. The results of Study 1 depicted a five-phase process that men go through, each time that they seek any type of help, for any type of IPA. These phases included: 1) Experiencing Distress/Abuse, 2) Recognizing Severity, 3) Realizing Limitations, 4) Deciding to Seek Help [Subphase a) Exploring Options, and Subphase b) Weighing Pros and Cons; both which were driven by a feeling of Ambivalence towards seeking help], and 5) Obtaining and Engaging in Help. For Study 2, I recruited eight participants who provided counselling services to stigmatized populations: six of whom provided counselling services to men who have experienced IPA, and two of whom provided counselling services to other stigmatized populations. The results of Study 2 depicted a three-phase process that counsellors go through, as they become someone who is willing to provide services to this population. Namely: 1) Realizing Severity, 2) Wanting to Help, and 3) Forming a Validating Connection [Subphase a) Recognizing Biases, and Subphase b) Addressing Biases].

The results of Study 1 align with previously postulated models of both general and IPA-specific help-seeking and add further depth and clarity regarding the specific processes involved. This model can be used to help service providers predict and subsequently address exit points for men in their help-seeking journeys. It further provides clarity regarding what needs to be addressed societally in order to further facilitate men's help-seeking. The model developed through Study 2 corroborates previous theoretical literature, which posits that professional and personal experiences are salient factors in counsellors' professional identity development.

Moreover, this model adds to the literature, as it allows for a description of the mechanisms through which these experiences affect professional development. Further, this model is unique in its clarification of the process counsellors go through in determining which populations to work with. This model can be used to predict when and why counsellors might choose to, or not to provide services to men who have experienced IPA and can be used to guide development of training and continuing education programs for professionals, in order to encourage better service provisions to men who have experienced IPA. These models elucidate the factors which can cause men and counsellors to egress the processes and can help to propagate ideas regarding how best to address these barriers. This is all done with the intention of increasing help-seeking amongst men who have experienced IPA, and of making their help-seeking and receiving experiences safer, easier, and more beneficial for them.

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Typology	Acronym	Definition
Situational Couple Violence	SCV	Abuse that occurs occasionally, when situations or arguments escalate into violence. It usually involves minor aggressive acts, and these acts are unlikely to escalate over time
Coercive Controlling Violence	IT	Abuse that includes multiple control tactics in the major categories of intimidation, emotional abuse, isolation, minimizing, denying and blaming, the use of children, male privilege, economic abuse, and coercion and threats
Violent Resistance	VR	Abuse that occurs when the non-perpetrator of IT fights back
Mutual Violent Control	MVC	A relationship in which both the man and the woman are violent and controlling
Separation-Instigated Violence	SIV	Relationship violence is instigated by a separation (e.g., divorce) and where there is no prior history of violence in the relationship or in other settings

Table 1.1. *Johnson's Typologies*

	Experiencing Distress/ Abuse	Recognizing Severity	Realizing Limitations	Deciding to Seek Help	Exploring Options	Weighing Pros and Cons	Obtaining and Engaging in Help
P1	√	√	√	√	√	√	√
P2	√	√	√	√	√	√	√
P3	√	√	√	√	√	√	√
P4	√	√	√	√	√	√	√
P5	√	√	√	√	√	√	√
P6*	√	√	√	√	√	√	
P7*	√	√	√	√	√	√	
P8	√	√	√	√	√	√	√
P9 (NC**)	√	√	√	√	√	√	√
P10 (NC)	√						

\*P6 and P7 were originally recruited as non-negative cases, but following the interview I determined that although they had sought help, they had not actually obtained and engaged in that help that they sought.

\*\*P9 was originally recruited as a negative case, but had sought help between screening and interview

Table 3.1. *Formal Saturation Check for Study 1*

Theory Name	Similarities	Contrast/Expansion of Model
Health Belief Model	<ul style="list-style-type: none"> <li>• Importance of recognizing severity of experience</li> <li>• Belief that help will be beneficial</li> <li>• Weighing the pros and cons/acknowledging barriers to help</li> <li>• Phase-based process</li> <li>• Importance of contextual factors</li> </ul>	<ul style="list-style-type: none"> <li>• No discussion of self-efficacy in my model</li> </ul>
Theory of Planned Behaviour	<ul style="list-style-type: none"> <li>• Weighing pros and cons (specifically with subjective masculinity norms)</li> <li>• Perceived behavioural control and accessibility of services as a facilitator for help-seeking</li> </ul>	
Network Episode Model	<ul style="list-style-type: none"> <li>• Importance of social influences</li> <li>• Importance of internal versus external motivations for seeking help</li> <li>• Phase-based process</li> </ul>	
Information Processing Model	<ul style="list-style-type: none"> <li>• Personal significance of symptoms (e.g., severity)</li> <li>• Evaluating help-options (i.e., is there something that can be done about my distress)</li> <li>• Exiting the help-seeking process due to unawareness of availability of help</li> <li>• Evaluating pros and cons of help</li> <li>• Importance of “outcome” of help-seeking on decisions of what to do next</li> </ul>	<ul style="list-style-type: none"> <li>• My model differentiates between evaluating options and weighing pros and cons, whereby Vogel et al.’s (2006) model considers them one phase (i.e., “exploring options”)</li> <li>• Evaluating and considering the outcomes of behaviour in my model occurs at both Phase 3 (with informal sources of help), and Phase 5 (with formal sources of help), as compared Vogel et al. (2006) claim that it occurs only in their fourth and final stage.</li> </ul>
Learned Helplessness Model		<ul style="list-style-type: none"> <li>• Help-seeking efforts increase as severity/recognition of abuse increased</li> </ul>
Survivor Model	<ul style="list-style-type: none"> <li>• Help-seeking efforts increase as severity/recognition of abuse increased</li> </ul>	
Barriers Model	<ul style="list-style-type: none"> <li>• Understanding of the impact of individual and structural level factors on help-seeking</li> </ul>	

Behavioural Model of Health Care Utilization	<ul style="list-style-type: none"> <li>• Importance of predisposing characteristics (e.g., traditional gender role adherence), enabling resources (e.g., awareness of resources, SES), and needs-based factors (e.g., symptom severity)</li> </ul>	
Rational Choice Model	<ul style="list-style-type: none"> <li>• Help-seeking decisions involve a complex process of weighing the costs and benefits of involving service providers in one's life</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded their results beyond the criminal justice system, to a variety of service providers</li> <li>• Importance of recognizing the different costs and benefits that come with different service providers</li> </ul>
Cognitive Process Model	<ul style="list-style-type: none"> <li>• Importance of recognizing severity of situation</li> <li>• Exploring options and making a decision to seek help</li> <li>• Importance of interpersonal and sociocultural factors throughout the models</li> </ul>	<ul style="list-style-type: none"> <li>• Addition of depth and complexity to the phases</li> <li>• Addition of a "Realizing Limitations" phase after Recognizing Severity phase</li> <li>• Contraindication of Liang et al.'s (2005) postulation that deciding to seek help is followed by determining available sources of help (i.e., much more complex process, that involves sub-phases and ambivalence)</li> <li>• My results indicate that help-seeking and help-receiving are distinct concepts</li> </ul>
Feminist Pathways Theoretical Model	<ul style="list-style-type: none"> <li>• Viewing help-seeking as a trajectory of behaviour</li> <li>• Understanding of help-seeker as a component of one's identity</li> </ul>	
Intimate Partner Stigmatization Model	<ul style="list-style-type: none"> <li>• Cultural, internalized, and expected stigmatization as barriers to help-seeking for IPA</li> </ul>	

Table 5.1. *Comparison of Study 1 Theory to Previous Help-Seeking Theories*

	Realizing Severity	Wanting to Help	Forming a Validating Connection	Recognizing Biases	Addressing Biases
P1	√	√	√	√	√
P2	√	√	√	√	√
P3	√	√	√	√	√
P4	√	√	√	√	√
P5	√	√	√	√	√
P6	√	√	√	√	√
P7 (NC)	√	√	√	√	√
P8 (NC)	√	√	√	√	√

Table 6.1. *Formal Saturation Check for Study 2*



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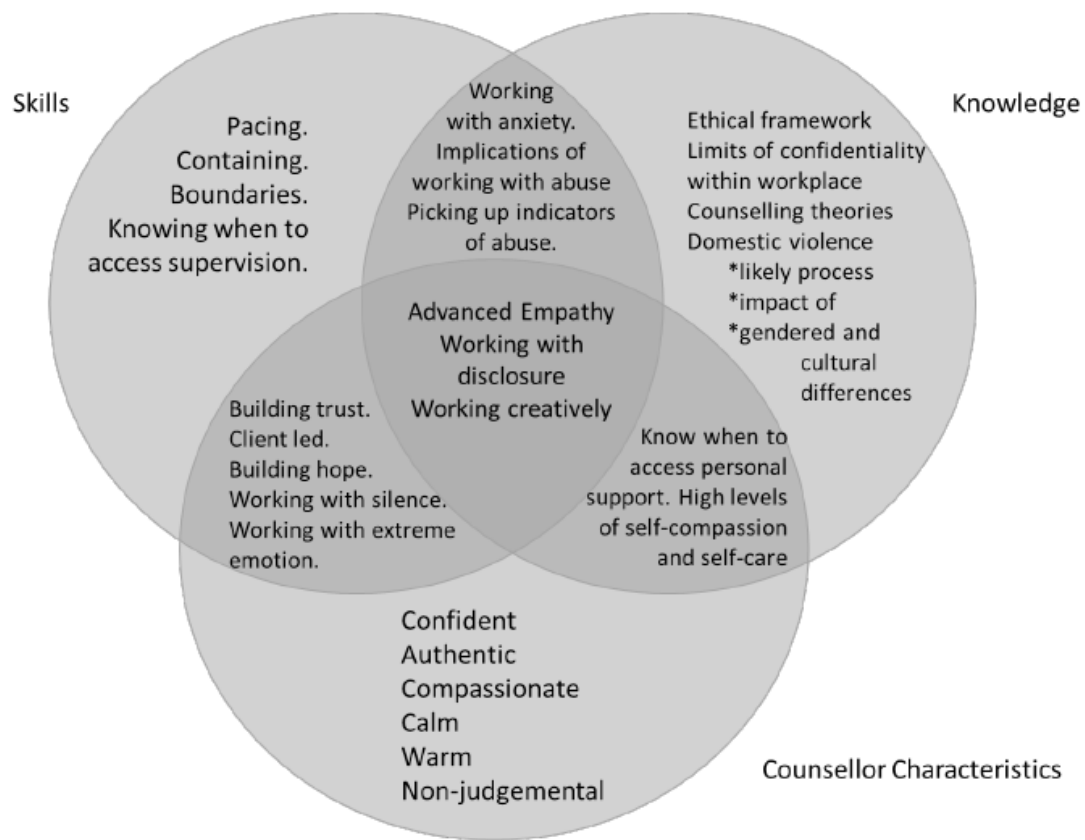


Figure 1.1 *Pictorial Representation of the Competency Framework for IPA Counselling*<sup>1</sup>

<sup>1</sup> Roddy & Gabriel, 2019

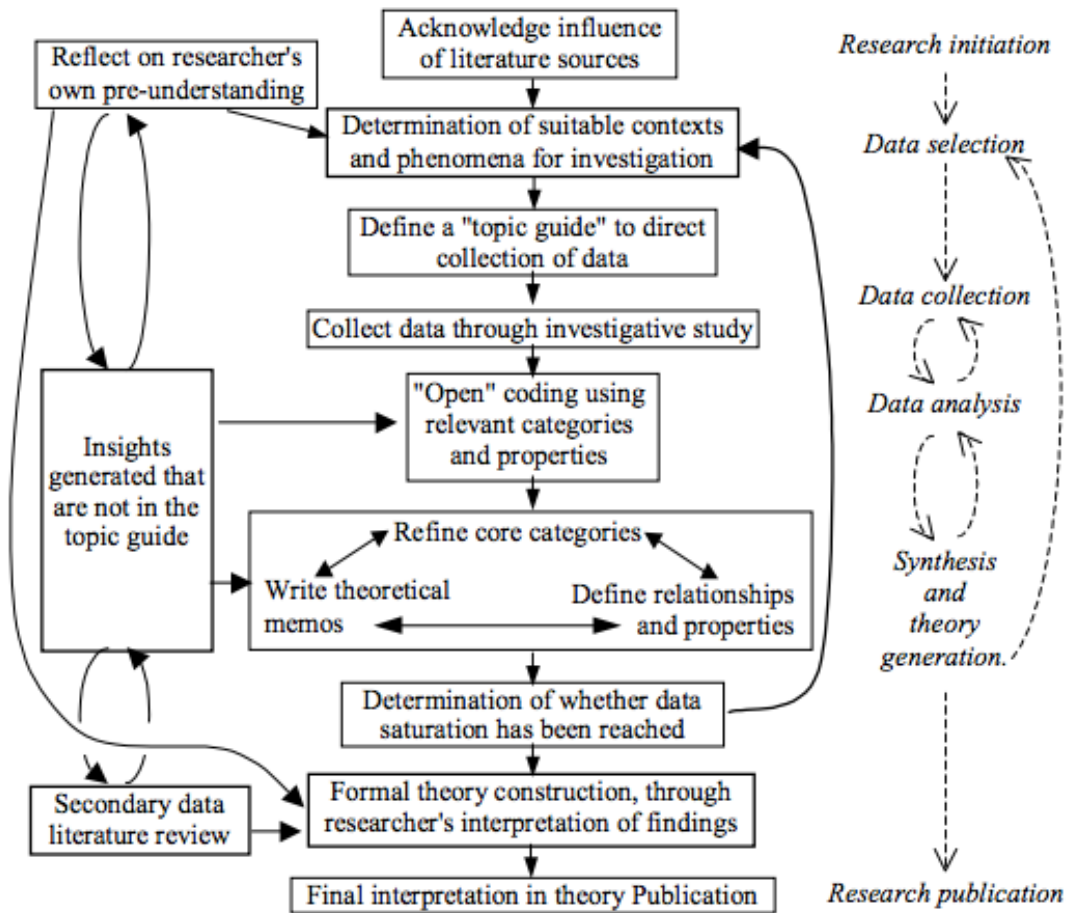


Figure 2.1. *Graphical Representation of a Reflexive Grounded Theory Approach*<sup>2</sup>

<sup>2</sup> Lowe, 1995; Pigeon & Henwood, 1996; Dey, 1999, adapted by Gasson, 2004

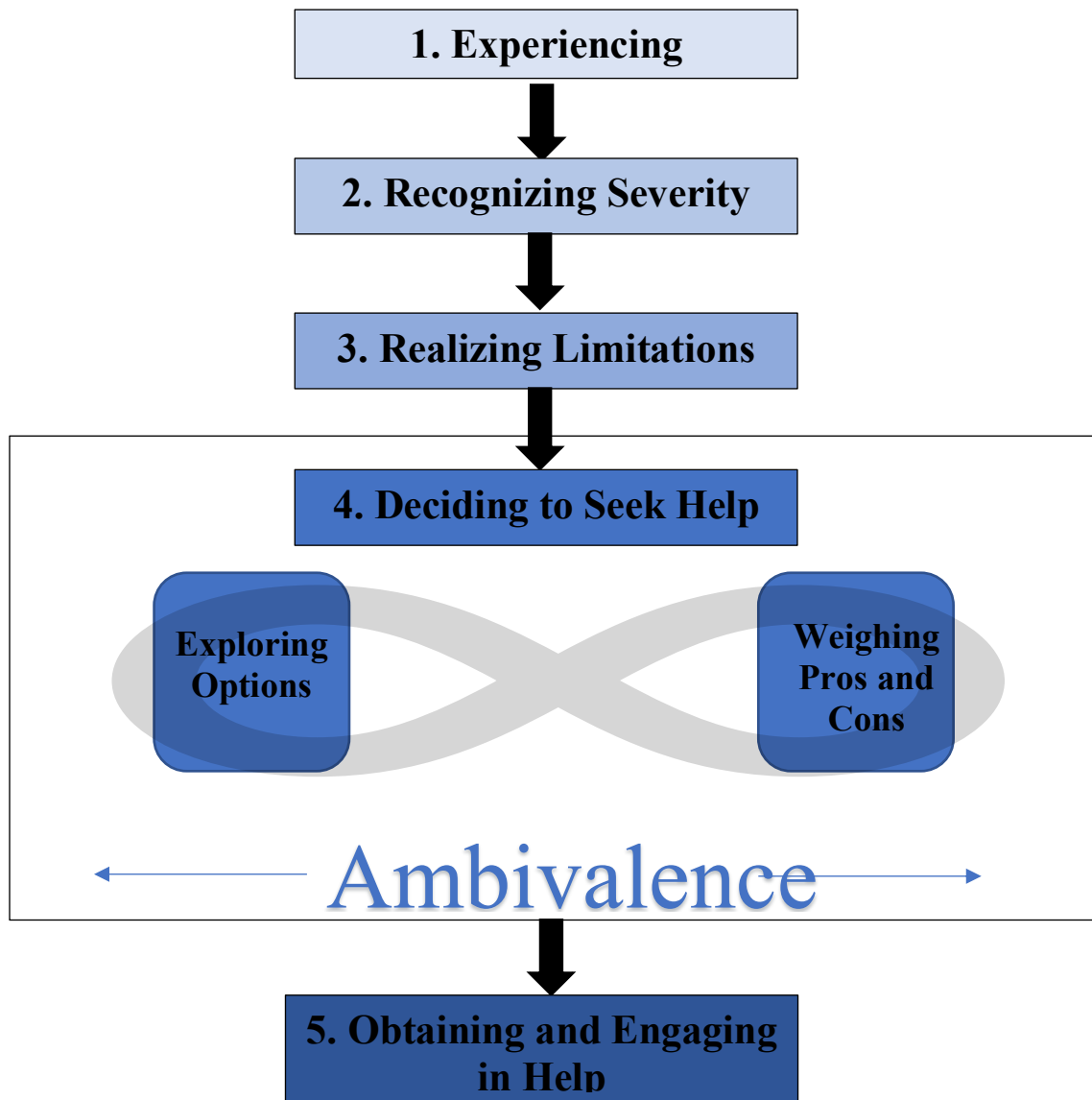


Figure 4.1 *Graphical Representation of Study 1 Theory*

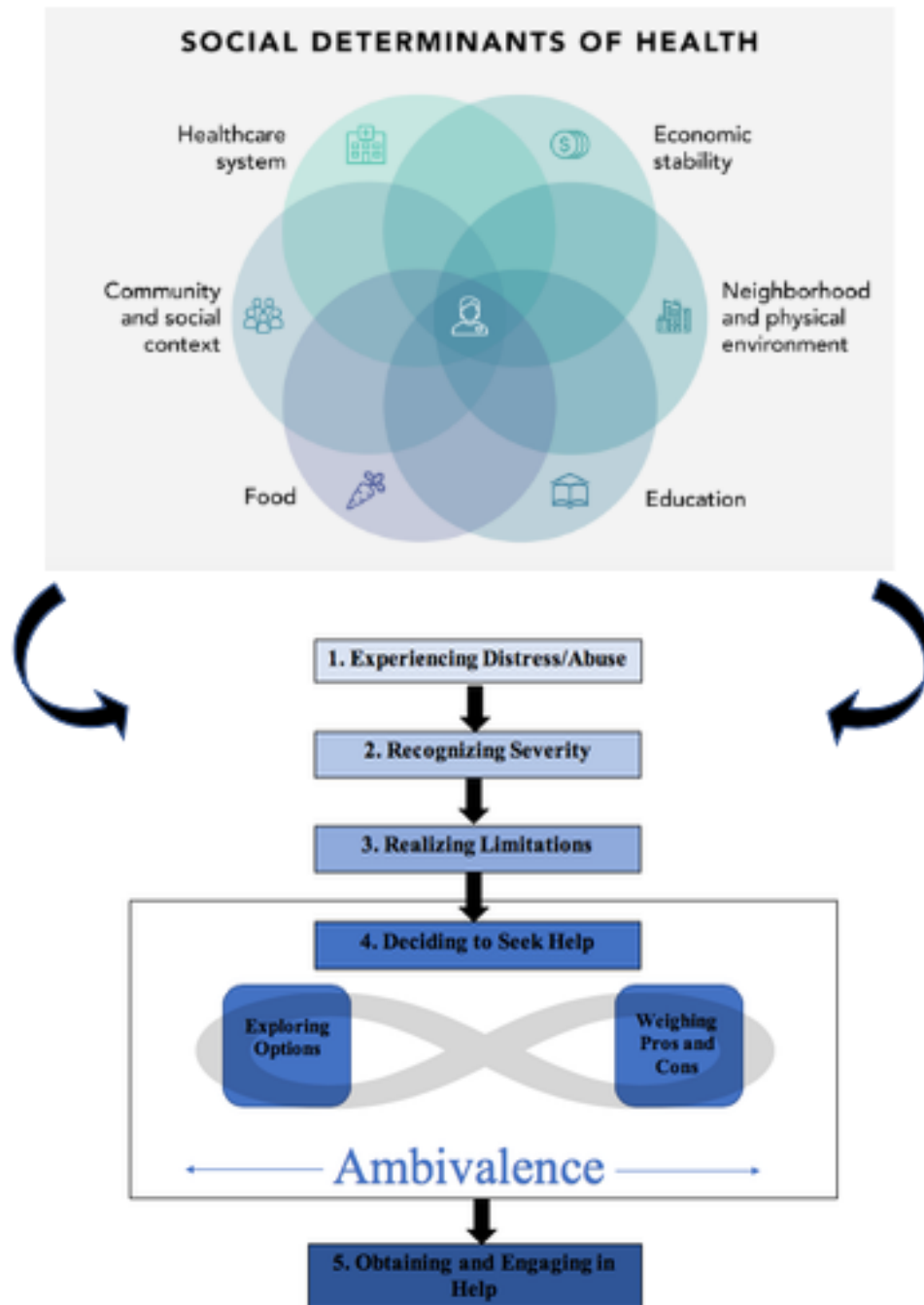


Figure 5.1. *Study 1 Theory in the Context of Social Determinants of Health*<sup>3</sup>

<sup>3</sup> Paruk, 2019

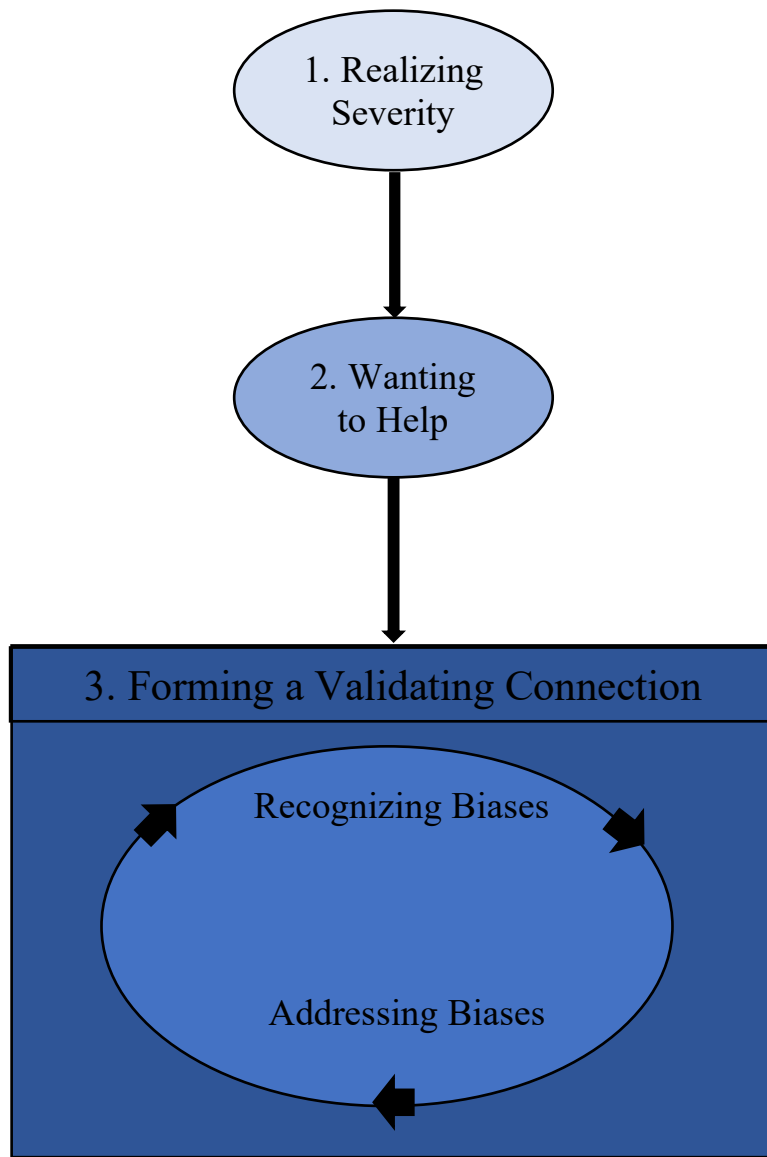


Figure 7.1. *Graphical Representation of Study 2 Theory*

## **CHAPTER 1: OVERVIEW AND LITERATURE REVIEW**

### **Dissertation Overview**

Intimate partner abuse (IPA) is a pervasive problem that has substantial financial, emotional, and physical costs, both to those who experience it and society at large (Wilson, 2014). It is abuse that can affect anyone regardless of race, gender, socioeconomic status, or sexuality (Walker & Gavin, 2011). However, societal awareness of and support for those who experience this abuse can differ based on these demographic variables. Men's experiences of IPA perpetrated by women is an area that has been historically disregarded but is gaining increasing societal, media, and research attention (Perry, 2014). A plethora of research studies indicate that men experience IPA at high rates, with some even indicating that men experience IPA at rates similar to that of women (e.g., Tjaden & Thoennes, 2000). These claims of similarity are at the forefront of what is known as the gender symmetry debate (Johnson, 1995), whereby researchers disagree concerning the accuracy of these claims that men experience IPA at rates similar to those of women. Specific lifetime prevalence studies in the United States show that over one quarter of men (28.5%) have experienced physical violence, rape, and/or stalking and nearly half of men have experienced psychological abuse by an intimate partner (Black et al., 2011). These experiences are related to increased risk for anxiety, post-traumatic stress disorder, depression, suicidal ideation, and worsened physical health (Carbone-López et al., 2006; Chan et al., 2008; Coker et al., 2002; Dickerson-Amaya & Coston, 2019; Próspero & Fawson, 2010; Reid et al., 2008). Thus, there is clear evidence that IPA can be perpetrated against men and can have enduring and deleterious effects on their physical and mental health (Berger et al., 2016; Carbone-López et al., 2006).

Despite these high rates of abuse and the associated negative consequences, men are reluctant to seek help for IPA (Laroche, 2005). When men do seek help, they are frequently discriminated against by service providers, such as being mocked for being abused by a woman, not being believed, and even being refused services (Hines et al., 2007; Stephenson, 2009). These negative responses by service providers can have harmful effects on the men seeking help, such as hindering them from leaving the relationship, resultant internalized denial of the abuse, and increased negative mental health symptoms (Douglas & Hines, 2011; Eckstein, 2009).

Researchers have developed numerous theories and models regarding general help-seeking processes, men's broad help-seeking processes, and help-seeking processes specific to

IPA (e.g., Andersen, 1995; Hammer & Vogel, 2013; Liang et al., 2005; Rosenstock, 1974). These processes have typically been developed through reviews of the literature, and/or quantitative research regarding important facets of the help-seeking process. However, no researchers have developed an inductive theory of help-seeking through an in-depth investigation of the lived experiences of the individuals who have sought help. Specifically, there has been no research done to investigate the *process* that men go through to seek and receive help for IPA. Given this two-fold gap in the literature, the aim of Study 1 of this dissertation was to investigate the process that men go through to seek help for IPA. To do this, I utilized grounded theory methodology to develop a theory regarding this process. The results of my grounded theory approach depicted a five-phase process that men who experience IPA go through, as they journey towards seeking help for IPA-related concerns.

A related part of this issue are the responses that service providers have towards men who experience IPA. Research indicates that service providers from various occupational backgrounds (e.g., police officers, counsellors, crisis workers), act prejudicially, or hold prejudicial attitudes towards this population (Follingstad et al., 2004; Hamilton & Worthen, 2011). Yet, there is a subset of service providers who acknowledge the hardships that these men face, and who advocate for an improvement in services, particularly counsellors (Hogan et al., 2012; Molloy, 2017; Wallace et al., 2019). A specific focus of my dissertation was on counsellors as a subset of these service providers, both due to my personal vested interest in counselling and therapy, and due to the applicable background literature surrounding counselling and counsellor processes. What arises from this discrepancy in viewpoints is the question of why and how some service providers (specifically counsellors) support and wish to provide effective services to these men, while others do not. Specifically, I was curious regarding the process that counsellors go through to become someone who provides services to men who experience IPA.

Within the literature, there is some research that helps to answer this aforementioned question. There are specific techniques and approaches which are particularly beneficial when providing counselling to men who have experienced IPA (Brosi & Carolan, 2006; Gold, 2019). Additionally, previous researchers have outlined specific competencies of counsellors which should be met prior to working with this population (Roddy & Gabriel, 2019). Researchers have further endeavoured to understand the process of counsellors' professional identity development. They have identified several personal experiences that can be integral to an individual's decision



to become counsellors (Bager-Charleson, 2010; Hill et al., 2013), as well as personal and professional experiences and factors that influence a counsellor's development of their professional identity (Burkholder, 2012; Gazzola et al., 2011; Rønnestad & Skovholt, 2003; Sawatzky et al., 1994). In addition, research on interactions with stigmatized populations<sup>4</sup> suggests that there are different processes that can diminish stigmatizing attitudes, namely contact with stigmatized populations (Allport, 1954; Lauber et al., 2006), and changing stereotypes (Biernat & Dovidio, 2000). The culmination of this research helps to provide some insight into how a counsellor becomes someone who provides beneficial services to men who experience IPA. However, it does not fully explain the process under investigation. Namely, there has been no research which has combined these research areas and investigated the process of counsellor development towards working with a specific stigmatized population. As a result, the aim of Study 2 of my dissertation was to investigate the process that counsellors go through to become someone who provides services to men who experience IPA. In order to meet this aim, I utilized grounded theory methodology to develop a theory regarding this process. Results of my grounded theory approach depicted a three-phase process that counsellors go through as they journey towards providing services to men who experience IPA.

The entirety of this project was completed through the lens of particular methodological, theoretical, ontological, and epistemological perspectives. I utilized constructivist grounded theory (Bryant, 2002; Charmaz, 2014, 2013, 2008, 2006, 2000; Clarke, 2005, 2006; Mills et al., 2006a; 2006b; 2006c) as my guiding methodology and method of analysis. I further adopted a social constructionist epistemology, whereby I hold the view that truth and meaning, and by extension my research data, are constructed through interactions with the world and the individuals within it (Crotty, 1998). I also ascribe to a relativist ontological position, meaning that I do not believe there to be any objective truth, but rather that knowledge is created through shared experiences and relationships with people (Charmaz, 2006).

At present there are few theories put forward to explain men's experiences of IPA. However, feminist theories have provided a thorough, applicable lens through which to describe men's experiences of IPA, women's perpetration of IPA, and the difficulties with help-seeking

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<sup>4</sup> I am conceptualizing men who experience IPA as a stigmatized population, due to the prejudicial responses that they receive from both society, and professionals

and help-providing that men and counsellors respectively might experience. As a result, I utilized anti-oppressive feminist theories and particularly the theoretical concept of hegemonic masculinity as my overarching theoretical perspective throughout this project. These theories together highlight the integral effect that the patriarchy, power differentials, and essentialist notions of gender roles (e.g., hegemonic masculinity) have on our society, and posits that these factors cause, exacerbate, and/or propagate systems of oppression, violence, stigma, and hurt that are commonplace in our society today. Anti-oppressive theories are further based in social-justice approaches, and they work to examine how different social identities influence people's lives and analyze how they may contribute to individuals' ongoing experiences of oppression (Dustin & Montgomery, 2010). In this way, the entirety of this dissertation was guided by the theoretical assertion that patriarchal systems operate to oppress and marginalize, that locations of difference and intersectionality are imperative and integral to analyses of power and feminist theorizing, and that we require action-based research in order to combat oppression.

### **Organization of the Dissertation**

In Chapter 1, I discuss the relevant existing literature underlying and contextualizing help-seeking and help-providing in the context of IPA. I review definitions and controversies present in the literature regarding IPA against men, discuss the existing research regarding men's experiences of abuse, and describe the physical, economic, and psychological toll that abuse takes on men. I then review theories relevant to men's help-seeking for IPA and discuss the identified barriers and facilitators for their help-seeking. Next, I discuss the literature surrounding service providers' perceptions of men who experience IPA, specifically narrowing my focus to counsellors who work with this population. I then review the literature surrounding competencies necessary when providing counselling to these men, as well as evidence-based therapeutic techniques. Last, I discuss the theoretical literature relevant towards "becoming" a counsellor who works with this population, including theories of professional identity development, the role of personal and professional experiences and motivations for becoming counsellors, as well as relevant theoretical literature surrounding counselling with stigmatized populations.

Chapter 2 involves review of the broad, overarching theories relevant to men's experiences of IPA (i.e., not those which describe the process of help-seeking, but which broadly identify theoretical bases for the enduring stigmatization and difficulties that men face when

seeking help, and that counsellors face when providing help). Specifically, I describe how an anti-oppressive feminist theoretical orientation guided my development, implementation, and interpretation of this project. I then provide a description of the various additional methodologies underlying this project (e.g., use of telephone interviews, cultural considerations, rigor and verification, description of grounded theory, epistemological and ontological perspectives). Chapter 3 and Chapter 4 encompass the methods and results of Study 1, with Chapter 5 being the discussion section for Study 1. In Chapter 6 and Chapter 7 I then describe the methods and results from Study 2, with Chapter 8 being the Study 2 discussion. Chapter 9 acts as the general discussion section, including a discussion of the overlap between Study 1 and 2, implications, future directions, and strengths and limitations. Last, Chapter 10 is dedicated to my reflexivity statement, where I discuss the various aspects of myself and my experience that I believed were influential throughout my dissertation project.

## **Literature Review**

### **Defining Abuse between Intimate Partners**

Abuse between intimate partners is known by many names, “including intimate partner violence, domestic violence, dating violence, domestic abuse, wife beating, wife battering, gender violence, and family violence, among others (Cook, 2009; Hamel, 2007)” (as cited in Shum-Pearce, 2016, p.10). One term that has gained increasing popularity within the literature on relationship violence and abuse is the term *intimate partner abuse*. Walker and Gavin (2011) suggest using the term IPA as opposed to commonly used terms such as intimate partner violence, domestic abuse, or marital violence, as it provides a more holistic definition that is unambiguous and can be appropriately applied across gender, abuse type, sexuality, ability, ethnicity, culture, religion, and socioeconomic status. These authors thus propose the following definition of IPA:

Any incident of coercive or controlling behaviours and strategies used by either a man or woman to gain power and control over their current or pre-existing intimate partner, whether of a heterosexual or same-sex nature. Incidents may include physical, psychological, emotional, verbal, sexual, financial or economic threat, abuse or violence including social isolation and stalking. Intimate partner abuse occurs across age, ability, culture, ethnicity, race, religion, and socioeconomic status whether married, cohabiting or dating. (p. 14-15)

In attending to the viewpoint that IPA can affect any and all individuals in intimate relationships, I use the term IPA throughout my dissertation. However, it should be noted that gender is an important concept within this definition. Walker and Gavin (2011) suggest IPA can be inflicted or endured by either a man or a woman. Yet, this aspect of the definition is unfortunately restrictive. As such, I would like to emphasize that IPA can occur across the entire gender spectrum and should not be limited by cis-normative understandings of ‘man’ and ‘woman.’

### ***Sexual Orientation***

In addition to defining IPA, it is important to emphasize that men across the sexuality spectrum can experience abuse. This abuse can be inflicted by a woman, a man, or a gender non-conforming partner. Moreover, research suggests IPA occurs at similar or at even higher rates amongst 2SLGBTQ+ individuals compared to those who do not identify as 2SLGBTQ+ (Bartholomew et al., 2008; Chesley et al., 1998; Messinger, 2011; Nowinski & Bowen, 2012).

However, there might be considerable differences amongst men’s experiences, both in terms of the abuse and help-seeking, depending on their sexual orientation. The importance of recognizing and attending to these differences is known as intersectionality. Intersectionality is “a dynamic concept that seeks to uncover oppression as it exists within, between, and in relation to social identity categories in their multiple interactions with the changing structural, political, and cultural levels of society” (Moosa-Mitha, 2005, p. 86). The guiding principle of an intersectional analysis is a focus on how people can hold multiple locations of difference at once, and these locations of difference can intersect and intertwine to result in a nuanced and multifaceted oppression of people (Mann & Grimes, 2001). Men in non-heterosexual relationships might experience multiple points of disadvantage, such as an interplay of the stigma associated with men’s experiences of IPA and potential stigmatizing reactions as a result of their sexuality.

Particularly, there is the issue of service providers’ perceptions of men who experience IPA being compounded by potential homophobia. Research indicates that police are less likely to intervene in gay and lesbian IPA cases, perhaps due to sexual prejudice (Renzetti, 1989). Further, even when the law is sufficient in protecting 2SLGBTQ+ persons, healthcare professionals might have prejudices toward, or lack the sensitivity required to work with, these individuals (Shipway, 2004). For example, an investigation of how crisis center workers addressed cases of

homosexual IPA showed workers rated same-sex IPA scenarios as less serious than heterosexual IPA and less likely to get worse over time (Brown & Groscup, 2009). However, researchers have also reported the opposite: that service providers can have more positive attitudes towards homosexual vs. heterosexual men who experience IPA (Hanna, 2015). Whether they are viewed more positively or negatively, it appears that the experiences of homosexual men who have survived IPA might differ significantly from those who are heterosexual.

Therefore, although the experiences of men in a variety of intimate relationships are important to investigate, my dissertation focused exclusively on men who experienced IPA from a woman perpetrator. This is due to the important nuances of intersectionality that would be missed should all men who experience IPA be investigated as one homogenous entity, and due to the potential confounding influence that sexuality might have on service providers' perceptions of men who experience IPA.

### **The Gender Symmetry Debate**

One topic that has been vehemently debated since the inception of the idea of “battered husbands” (Steinmetz, 1977) has been labelled “the gender symmetry debate” (Dobash & Dobash, 2004). One side of the debate, typically labelled the “gender paradigm perspective,” posits that heterosexual IPA is predominantly comprised of men who abuse their intimate partners (Dobash et al., 1992; Johnson, 1995; Kurz, 1989). The gender paradigm perspective has traditionally been the most common understanding of IPA (Pagelow & Pagelow, 1984; Walker, 1989).

The other side, typically labelled the “family violence perspective” or the “gender-neutral” perspective, suggests that women are violent in their relationships at rates similar to those of men (Straus, 1999). The gender-neutral perspective began with Steinmetz (1977), Straus et al. (1980), and Straus & Gelles (1990), who initially claimed that rates of violence by men and women in intimate partner relationships were comparable to each other. This perspective continues to be advocated for fervently, particularly by Dutton and colleagues (Dutton & Nicholls, 2005; Dutton, 2006a, 2006b, 2010; Dutton & Corvo, 2007).

A plethora of research studies and commentaries arose from this initial suggestion of symmetry between men's and women's perpetration and experiences of IPA. These empirical studies have proven inconclusive regarding this symmetry debate, such that evidence has been found for the majority of IPA being perpetrated by men (e.g., Bensley et al., 1998; Dobash et al.,

1992; Tjaden & Thoennes, 2000) and equal perpetration between men and women (e.g., Archer, 2000; Dutton & Nicholls, 2005; Straus, 2008; Straus & Gozjolko, 2014).

Within these commentaries and articles are numerous postulations regarding the “causes” of these discrepancies in IPA perpetration data. Johnson is at the heart of this issue and suggests the answer to the gender symmetry debate is as follows: “(a) partner violence is not a unitary phenomenon, (b) the two groups of researchers generally use different sampling strategies, (c) the different sampling strategies tap different types of partner violence, and (d) these types differ in their relationship to gender” (Johnson, 2006, p. 1004). Johnson (1995) argues that differences in researchers’ approaches to sampling are the predominant source of inconsistencies between the gender-paradigm and gender-neutral perspectives. Specifically, studies that depict a predominance of men’s violence used agency data (e.g., courts, shelters) whereas those that show gender symmetry involved community samples.

As such, Johnson (1995) argues these samples also capture fundamentally different types of violence: IPA seen in agency settings is more likely to be frequent, to escalate and be more severe, and less often mutual than what is seen in representative or community samples. This is said to be a better measure of the abuse that is based on concepts of patriarchy and men’s dominance, as this form of violence is more likely to result in injury or formal intervention (Krey, 2016). Conversely, the violence seen in the representative samples is likely less severe, and more “situational” and “typical” of general relationship conflict (Krey, 2016). Krey (2016) posits that this is a measure of violence that is resultant from every-day stressors and conflicts in relationships and is the most common type of violence in relationships (Krey, 2016). As a result, Johnson (1995) developed a number of violence typologies (described below), which he believed differentiated between these different types of violence seen in different settings, and which he postulated would be the likely answer to the gender symmetry debate.

Specifically, Ansara and Hindin (2010) note that Johnson “distinguishes the gender symmetric pattern of ‘situational couple violence’ from the gender asymmetric pattern of ‘intimate terrorism’” (IT<sup>5</sup>; now known as coercive controlling violence; p. 1011). Johnson (1995) suggests that proponents of the gender-neutral view are capturing situational couple violence in

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<sup>5</sup>Coercive Controlling Violence was previously known as Intimate Terrorism or IT. However, it will be referred to as IT throughout this paper, given that the acronym of CCV has typically been used to refer to “common couple violence” or what is now known as SCV

their data, which encompasses the typically less severe, often bidirectional abuse, between couples. Conversely, proponents of the gender-paradigm view are gathering data from individuals who have experienced intimate terrorism, the controlling, abusive, severe, and dangerous form of IPA that is predominantly perpetrated by men against women. As such, Johnson and Ferraro (2000) state that “our ability to draw firm conclusions and to develop effective policies is broadly handicapped by a failure to make distinctions among types of partner violence” (p. 948).

Thus, based on this logic one would assume that research accounting for different typologies of IPA would “solve” the gender symmetry debate. Research that does account for these typologies has consistently found that gender-symmetry in perpetration and experiences of SCV (Kwong et al., 1999), which is in alignment with Johnson’s (1995) theory. However, no consensus has been reached with respect to symmetry in perpetration and experiences of IT (detailed above). Both quantitative and qualitative studies have returned inconclusive results: some studies appear to find gender symmetry in experiences of IT (Ehrensaft et al., 2004), predominantly IT perpetrated by men (Johnson, 2006), predominantly IT perpetrated by women (Hines & Douglas, 2019), and what points to qualitatively different forms of IT experiences between men and women (Jasinski et al., 2014). In sum, the development of these typologies has not appeared to solve this debate.

Also central to the gender symmetry debate is the extensive critique of the tool commonly used to measure IPA. This tool is known as the Conflicts Tactics Scale (CTS; Straus & Gelles, 1990), which has been critiqued since its inception (Dobash et al., 1992). Research utilizing the original CTS depicts partner abuse perpetrated by both men and women at similar levels (e.g., Brinkerhoff & Lupri, 1988; Straus & Gelles, 1988, 1990; Straus et al., 1980). These findings are in contrast to data gathered from other methods (e.g., police recorded data and national surveys) which depict gender asymmetry (e.g., Byles, 1978, Chester & Streather 1972; Vanfossen, 1979).

Because this result goes against a widespread acceptance of IPA as a patriarchal exertion of men’s power against women (Pagelow & Pagelow, 1984), questions arose regarding the validity and reliability of this tool. Dobash et al. (1992) and Dobash and Dobash (2004) were at the forefront of critiquing the CTS. In summarizing theirs and others’ critiques of this measure, Dobach et al. (1992) identifies the following as significant concerns associated with the CTS: 1)

it essentially ignores context when measuring acts of abuse (e.g., precipitating events, sequences of events, and outcomes), 2) other forms of abuse (e.g., sexual assault) are largely ignored, 3) retrospective reports of abuse experiences are necessarily limited, 4) the distinction between severe and minor abuse is poorly operationalized, 4) equates assumptions of honesty in aggressor and victim reports (despite evidence of inconsistencies).

As a result, Straus et al. (1996) made revisions in an attempt to address some of the aforementioned critiques of the CTS and created the CTS-2. Jones and colleague (2017) note that the authors distinguished between minor and severe conflict tactics, increased the number of acts measured, measured injury and sexual coercion, and further operationally defines terms used in the measure. Yet, various studies that have utilized this revised scale continued to find that women perpetrate IPA at rates at least as high as men (Douglas & Straus, 2006; Hines & Saudino, 2003) as well as evidence for greater perpetration amongst men (Tjaden & Thoennes, 2000). As such, various critiques of the CTS-2 persist in terms of wording and application (Jones et al., 2017), but it remains the most widely used measure of IPA to date (Montesino & Gomez, 2018).

A review of this long-standing debate leads one to ask whether the time and energy devoted to proving either side wrong is worthwhile. McHugh et al. (2005) argue that accepting either view, that IPA is predominantly men abusing women or is gender symmetric, “limits our conceptual framework and results in tunnel vision” (p. 323). To them, the debate is an unfruitful and unnecessary conversation that does not advance theory or practice in the area. This perspective has been echoed by various other authors as well, who claim that asking whether IPA is symmetrical or asymmetrical across genders is an unnecessary and unhelpful question (e.g., Dim, 2017; George, 2003).

However, many people advocate for the gender-paradigm side for a variety of reasons. First and foremost, the gender-paradigm side appears to be rooted in a strong belief that IPA is a “manifestation of power and control, and the demonstration of a sense of possessiveness and entitlement” and “to say that women are equally violent is a way of denying that inequality exists in society or that women are oppressed” (Kaganas, 2006, pg. 147). For example, MacKinnon (1989), as cited in Kaganas (2006) notes that “All of this ‘men too’ stuff means that people don’t really believe that women are victims of anything anymore” (p. 171). Further, gender-paradigm advocates are concerned that the debate acts as an argument through which men and fathers are



rendered “safe,” such that if we assert that women are as violent as men then we lose the ability to focus on men “as a source of danger to their partners” (Kaganas, 2006, p.148). Kaganas (2006) further question the motivation behind men’s groups and researchers who are working to highlight women’s abuse towards male partners as a serious societal issue. They suggests this would be understandable if these endeavours were made with the intention of drawing attention to unmet needs of men who experience IPA. However, Kaganas (2006) notes that advocating for gender symmetry does not seem to be done with that intention. Rather, many writers suggest that what is underlying research into equivalence is a desire to overshadow the occurrence of gender inequality in society (Kaganas, 2006).

Conversely, proponents of the gender-symmetry debate have worked hard to establish the gender-neutral nature of IPA. Dutton (2006a, 2006b, 2010, 2012) has been a particularly vocal advocate for the gender-neutral side of the debate. He claims the gender-paradigm underestimates the incidence and severity of women’s use of violence, and this has an enduring effect on service providers, particularly custody evaluations (Dutton, 2006b). This paradigm makes men’s violence appear more commonplace than it truly is and thus ignores and minimizes women’s violence, which means that it is often not subjected to state intervention (Dutton, 2010). He further postulates that the gender paradigm has led to enduring stereotypes, which have permeated both community and service providers’ perceptions and result in amplification of the perceived severity of men’s violence and the minimization of women’s violence, particularly when men go to seek help (Dutton, 2012).

Clearly, advocates for all three positions have strong rationales for their dedication to gender-symmetry, gender-paradigm, or the argument-futility sides of the debate. What has resulted is a type of dogmatism amongst researchers, where many, if not all proponents of their positions, are unwilling to shift their views. As such, several other researchers in IPA have claimed that the truth of IPA is being obscured by authors’ dedication to their own theoretical paradigm (Dutton & Nicholls, 2005; Archer, 2000). Instead of allowing the data to depict trends in IPA and utilizing those trends to generate new or more accurate theories, these authors suggest some researchers are so inflexible in their theoretical paradigms that any data that contradict their position or method utilized to gather such data must be flawed (Krey, 2016).

## ***Summary***

In sum, no conclusions can be drawn at this point as to the gender-symmetrical or gender-neutral nature of IPA, nor will I advocate for either side of this debate through my dissertation. At the root of the IPA research is evidence that men can, and do, experience all types of IPA. As such, one of the aims of this dissertation is to identify needs of men who experience IPA that remain unmet, and to elucidate potential methods to address these needs. This is not an attempt to divert attention from the gender inequality inherent in many instances of women's experiences of IPA, nor is it an attempt to suggest the experiences of a particular gender is more or less important than that of the other. Men are experiencing and suffering from IPA, regardless of the comparability of its frequency, intensity, or cause, to women's experiences.

## **Types and Typologies of Abuse**

### ***Types***

As mentioned above in Walker and Gavin's (2011) definition, there are various types of IPA. Physical, sexual, emotional, social, economic, and psychological threat, and abuse or violence including social isolation and stalking can all occur within the context of an intimate relationship (Walker & Gavin, 2011). Physical abuse is one of the most studied and well-recognized forms of IPA (Outlaw, 2009). It is also one often the most obvious, and consists of bruises, cuts, broken bones, slapping, hitting, the use of weapons, and even homicide (Smith & Powell, 1989). Sexual abuse can take the form of rape, attempted rape, assaults on sexualized body parts, requiring sexual acts, threatening sexual assault, and sexual coercion, and is often used to demean and control the individual (Smith & Powell, 1989). Forced (e.g., "My partner used threats to make me have sex") and insisted (e.g., "My partner insisted on sex when I did not want to [but did not use physical force]") sexual IPA is also an emerging area of research, particularly with men (Próspero & Fawson, 2010, p. 10). Emotional abuse can include constant criticism, name-calling, and minimizing a person's abilities (Smith & Powell, 1989). Social abuse usually involves forcing the partner into isolation, and restricting their connections with friends and family, either by threat, force, or persuasion (Outlaw, 2009). Economic abuse is characterized by keeping the partner dependent on the offender, which can take the form of prohibiting the victim from access to household money, from opening bank accounts or obtaining credit, or preventing the individual from keeping or getting a job (Smith & Powell, 1989). Last, psychological abuse is that where offenders traumatize their partner through

intimidation and threats (Smith & Powell, 1989). Often this is seen in threats aimed at the partner's support system, and similar to social abuse, isolation, such that the offender is their only support (Smith & Powell, 1989). Although not widely recognized, researchers studying men who experience IPA in Australia have identified an additional form of abuse, which they labelled legal-administrative abuse (Tillbrook et al., 2010). This involves a partner accessing services in a dishonest or manipulative way, such as a woman filing a restraining order against a man who she is abusing, or claiming that IPA was perpetrated against her, but without substantial cause (Tillbrook et al., 2010).

Several studies also depict prevalence estimates and compare prevalence rates of types of abuse between men and women. Research shows non-physical abuse is the most prevalent form of abuse within intimate relationships and is particularly high among individuals experiencing comorbid physical abuse (Outlaw, 2009). Further comparison of prevalence estimates suggests psychological abuse is more often experienced by men than women (Paul et al., 2006). This has been corroborated by additional research, where Outlaw (2009) found that "women are in some cases equally likely, and in others more likely, to abuse their partners in a non-physical way than are men" (p. 270). Felson (1996), as cited in Outlaw (2009) suggests that women choose these non-physical forms of abuse because they are more likely to be successful with them and because they might be viewed as more consistent with their gender socialization than violence. Differentiating between types of abuse can be helpful in guiding research into how they can affect people in different ways. For example, Nybergh et al. (2016) found that women's use of emotional abuse was used to successfully control their partners, whereas physical and sexual abuse methods typically were not as effective.

### ***Typologies***

In addition to differentiating between types of abuse, researchers delineate different *typologies* of IPA. Nybergh et al. (2016) note that Johnson's work on different typologies or categories of IPA (Johnson, 1995, 2006; Kelly & Johnson 2008) is one of the most significant contributions to theorizing about men's experiences of IPA. Furthermore, as will be discussed below, these typologies have also been posited as potential explanations, or mediators, in the gender symmetry debate (Johnson, 1995). Kelly and Johnson (2008) suggest that differentiating among typologies of IPA is necessary in order for appropriate and accurate screening instruments and processes to be developed. They note this can result in improved decision

making, appropriate consequences and sanctions for abusers, and more effective treatment and recovery programs, which can be tailored to the different typologies of IPA. For example, typologies appear to predict outcomes of abuse (e.g., extent, severity, and after-effects), and thus can assist service providers in referring individuals to appropriate services (e.g., couples counselling versus police intervention; Kelly & Johnson, 2008). Kelly and Johnson (2008) provide an extensive review of these five typologies, and a brief overview based on their review is provided below (see Table 1.1 for a visual depiction of typologies, acronyms, and definitions).

According to Kelly and Johnson (2008), Situational Couple Violence (SCV) is the most common type of physical aggression amongst both male and female intimate partners. SCV occurs occasionally, when situations or arguments escalate into violence. It usually involves minor aggressive acts (e.g., pushing, shoving, and grabbing), although they can be severe, and these acts are unlikely to escalate over time. SCV generally does not involve patterns of control, and fear of the partner is not characteristic. Kelly and Johnson (2008) reviewed research which suggests that SCV is perpetrated at similar rates by women and men (Kwong et al., 1999; Straus & Gelles, 1992), though some suggest higher rates of violence perpetration among women (Capaldi & Owen, 2001; Douglas & Straus, 2006). This violence can involve one incident, sporadic incidents, or can occur regularly (Kelly & Johnson, 2008). More frequent SCV is related to more severe violence (Kelly & Johnson, 2008). However, the violence seen in SCV is typically less severe, and less frequent, than the violence seen in coercive controlling violence (Straus, 1990).

Coercive Controlling Violence (IT<sup>6</sup>) is the type of IPA most frequently seen in agency settings (e.g., law enforcement, courts, and shelters; Kelly & Johnson, 2008). IT “includes multiple control tactics, of which the major categories are intimidation, emotional abuse, isolation, minimizing, denying and blaming, the use of children, male privilege, economic abuse, and coercion and threats” (Johnson, 2006, as cited in Nybergh et al., 2016, p. 5). Due to the efficacy of nonviolent control tactics in the absence of violence (particularly if there is a history of violence), IT does not necessarily elicit high frequency of physical violence (Kelly & Johnson, 2008). However, IT is typically associated with violence that is severe and escalates over time

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<sup>6</sup> Coercive Controlling Violence was previously known as Intimate Terrorism or IT. However, it will still be referred to as IT throughout this paper given that the acronym of CCV has typically been used to refer to ‘common couple violence’ or what is now known as SCV

(Johnson, 2006). Within heterosexual relationships, IT is said to be perpetrated primarily by men (i.e., 87-97%; Johnson, 2006; Graham-Kevan & Archer, 2003). Researchers suggest that this type of abuse aligns with feminist theories, “where men are trying to exert and maintain control over “their” women” (Johnson, 1995, 2006; Johnson & Ferraro, 2000; as cited in Hines & Douglas, 2010, p.4). However, the above-mentioned statistics (Johnson, 2006; Graham-Kevan & Archer, 2003) indicate that approximately 3-13% of IT is perpetrated by women. Further, qualitative research into men’s experiences with IPA suggests that men do experience the controlling behaviours and power assertions characteristic of IT (Felson & Messner, 2000; Graham-Kevan & Archer, 2003; Hines et al., 2007; Migliaccio, 2002; Nybergh et al., 2016; Straus, 2008). Further, population-based studies (i.e., Ehrensaft et al., 2004; Laroche, 2005), have depicted that rates of IT perpetration are comparable between men and women. Ehrensaft et al., (2004) found that in New Zealand there is a prevalence rate of IT of 9%, with the likelihood of perpetration equal between women and men. The results from Laroche (2005) show that the majority of cases of IPA reported could be categorized as IT, with rates slightly lower amongst men (67%) than women (79%). More recent research in Canada shows that 35% of male and 34% of females who experience IPA experienced high controlling behaviors which the authors characterized as IT (Lysova et al., 2019).

Furthermore, Hines and Douglas (2010a, 2010b) investigated the occurrence of IT and SCV in a sample of men and women from community and help-seeking samples. The men in the help-seeking sample reported their IPA experiences in a fashion very similar to Johnson’s (1995) description of IT. Specifically, among the men and women who utilized physical and psychological aggression, the women used physical aggression, severe psychological abuse, and controlling acts 5-6 times more than the men. Further, the rates of these aggressive acts were twice as high among the women compared to the men, and the help-seeking men were injured twice as frequently as their women partners. Furthermore, the number of violent acts the men experienced in the previous year (46.72 acts) was found to be comparable to the frequency of acts seen in sample of women who have experienced IT (i.e., between 15 and 68 acts per year; Johnson, 2006; Straus, 1990; as cited in Hines & Douglas, 2010b).

Hines and Douglas (2010a, 2010b) further reported evidence of IT against men in this study when they compared the help-seeking sample with the community sample. Specifically, the women partners of men who had sought help showed significantly higher rates and

frequencies of all types of IPA perpetration, compared to the community sample (i.e., “they were 54 [controlling behaviours] to 407 [minor physical aggression] times more likely to use [IPA]; Hines & Douglas, 2010b, p.12). Further, women partners in the help-seeking sample had significantly higher frequencies of IPA perpetration than the community sample, ranging from 1.5 times (sexual aggression, severe physical aggression) to over 3.75 times (controlling behaviours, total physical aggression) that of the community sample. They further found that help-seeking men were 90 times more likely to have experienced an injury in the last year, compared to men in the community sample. More research recent further corroborates the existence of IT perpetrated against men. Specifically, Hines and Douglas (2018) found that the mental health of men who experienced IT was significantly worse than those who experienced SCV. Further, they found that men who experienced IT also were exposed to more severe and frequent IPA, including physical, sexual, and non-physical types of IPA. Men who experienced IT also had worse physical and mental health than men who perpetrated IT or experienced MVC.

Last, Jasinski et al. (2014) used data from the National Violence Against Women Survey to compare rates of women’s and men’s experiences of IT. Their results show that IT can have different characteristics when perpetrated against men compared to when perpetrated against women. Specifically, contrary to Johnson’s (1995) hypotheses about IT, Jaskinski et al, (2014) found that men who were involved in relationships characterized by IT did not miss work more frequently, were not more likely to be injured, and were not more likely to report symptoms of depression compared to men involved in SCV relationships. However, compared to those in relationships characterized by SCV, men in IT relationships reported greater symptoms of post-traumatic stress disorder (PTSD) and were more likely to leave their wives. In addition, Jasinski et al. (2014) found women and men experienced IT at similar rates (36% vs. 35% respectively). Further, the violence experienced by men and women was similarly severe and frequent, and both men and women who experienced IT experienced similar levels of depression and PTSD symptomology and missed similar rates of work.

In sum, men do experience IT in their intimate relationships. What is unclear is whether they experience it at similar rates as women and whether the IT they experience is in an identical form to that experienced by women. However, the IT that men experience is real, severe, and detrimental, and thus should not be disregarded. IT does not appear to simply be a result of

men's patriarchal power and control over women, but rather something much more nuanced and wide-reaching.

The third type of abuse is Violent Resistance (VR). This type involves partner abuse that occurs when the non-perpetrator of IT fights back. Here, the partner is not attempting to establish control in the relationship but is fighting as a method of defense. VR is typically the most-cited reason for women using violence in intimate relationships, and Johnson (1995, 2006) posits that VR is almost exclusively committed by women. As such, research into the use of VR by men has been very limited. Yet, in interviews with men calling an abuse hotline, Hines and colleagues (2007) encountered a man who reported that he "tried to fight her off, but she was too strong" (p. 66), which indicates the potential for the use of VR by men in heterosexual relationships. Further, Hines and Douglas (2011) found evidence for the use of VR among men. Specifically, their results show that 55% of help-seeking men in their sample used violence and 19.5% used severe violence. They compared this result with studies of women who experienced IPA who had sought help from shelters and were asked about their own perpetration of physical IPA. These studies (Giles-Sims, 1983; McDonald et al., 2009, as cited in Hines & Douglas, 2011) showed that 50-75% of help-seeking women in shelters indicated they had used physical violence against their partner within a year of coming to the shelter, and that 50-67% reported engaging in severe violence (e.g., beat up a partner, used a knife or gun). This indicates that the help-seeking men in Hines and Douglas's (2010a, 2010b) studies are using violence at similar rates as help-seeking women. Hines and Douglas postulated that this use of violence can likely be conceptualized by one of Johnson's typologies of IPA, namely Mutual Violent Control (see below), or VR. They hypothesized that it was likely VR given that the help-seeking men's rates of IPA were lower than those of their women partners. In their sample, the community sample of men reported significantly higher rates of control and physical violence than the help-seeking sample (despite the converse pattern when reporting IPA), which suggests the sample of help-seeking men are more likely utilizing VR, as opposed to MVC.

The fourth type is Mutual Violent Control (MVC). This type describes a relationship in which both partners are violent and controlling and is the rarest of the IPA typologies (Johnson, 2006). Essentially, this typology encompasses a relationship where both partners are perpetrators and experiencers of IT. When Johnson (2005, 2008) revised his violence typologies, he excluded MVC on the basis that it rarely occurred (e.g., 1%; Johnson & Ferraro, 2000) and that, in the

past, research studies misinterpreted this type of violence by viewing it as either an act of IT resulting in VR from the abused partner or SCV. However, a study by Próspero (2008) found a significant percentage of MVC amongst the sample, and these MVC couples were significantly more likely to report symptoms of depression and anxiety, feelings of hostility, somatic symptoms, and physical injuries, than SCV couples. However minimal research has been conducted due to the relatively rare occurrence of this typology.

Last, Separation-Instigated Violence (SIV) is a specific violence typology, whereby violence is instigated by a separation (e.g., divorce) and where there is no prior history of violence (Kelly & Johnson, 2008). This type of violence is said to be seen similarly among men and women and is usually unexpected and uncharacteristic of the perpetrator. It is typically triggered by traumatic separation experiences (e.g., discovery of infidelity, partner moved out and child taken while the other parent is at work) and involves an “atypical and serious loss of psychological control” (Kelly & Johnson, 2008, p. 487). This typology has also been neglected in the literature with limited research into its occurrence.

### ***Summary***

I reviewed the above studies to emphasize that IPA is not a unitary phenomenon and that important nuances and differences exist amongst types of, and reasons for, IPA. Important contextual factors influence how it is experienced and what types of consequences emerge for the abused partner, and these aforementioned typologies have been presented as helpful guidelines for understanding these nuances. With regards to the men who were the focus of this study, it is possible that different typologies of violence correlate with different help-seeking experiences. However, I did not include or exclude participants on the basis of the “typology” or “type” of violence that they have endured, nor did I apply this framework in a deductive manner. Rather, through analyzing their stories, I aimed to inductively elucidate potential differences among their experiences, which might align with differences between types and typologies of abuse. From there, we might be better able to see if typologies and/or types of abuse influence both help-seeking behaviours and/or help-seeking experiences. I will revisit the link between my participants and these typologies in the discussion section.



## **Men's Experiences of Abuse**

Although men's broad personal experiences of abuse are not the specific focus of my dissertation, parts of men's experiences, such as the path of their abuse, their intimate relationships, and social influences, will likely affect their help-seeking decisions and actions and, thus, are briefly discussed below. Relevant to my own use of qualitative methods, many of these studies have used qualitative research methods to investigate these experiences.

### ***Path of Abuse***

In general, research suggests that when abuse is perpetrated against a man it takes a similar path as when perpetrated against a woman. Migliaccio's (2002) research was one of the first to show this similar pattern. In this study, men reported that violence was typically introduced into the relationship following a commitment such as marriage, and then followed by a steady increase of physical assault. This was accompanied by extreme verbal abuse, which worked to lower the men's self-esteem and convince them they were partially to blame for the abuse. Similarly, Park et al. (2020) found that violence would typically begin with minor or temporary incidents; however, it would escalate over time, and would eventually become part of men's daily routine. Further, the partners' excessive verbal abuse and constant blame worked to lower the men's self-esteem. Research also shows that men tend to rationalize and/or deny the presence of violence, either because they truly believed there was no violence or had convinced themselves their spouses would change (Migliaccio, 2002). Eventually, the men either realized their spouses would never change and subsequently ended the marriage or chose to stay and found ways to deal with the abuse (e.g., attempts to placate or avoid their wives, expressions of retaliatory violence, and consideration of suicide; Migliaccio, 2002).

Some men have also reported experiencing a cycle whereby "explosions" characterized the early relationship and then, as the relationship continued, a circular pattern of tension, abuse, and then a honeymoon phase persisted, a pattern typically seen in studies of women's experiences of IPA (Entilli & Cipolletta, 2017; Park et al., 2020). In addition, later phases of the relationship typically involved more psychological and emotional abuse, and men only acted on the abuse (e.g., sought help) when it was harming someone other than themselves (e.g., children). Furthermore, Nayback-Beebe and Yoder (2012) found that, throughout this cycle of abuse, one individual (i.e., a case study) described the process of defining and redefining his values and beliefs to accommodate the abusive behaviours from his spouse. He further described

blaming himself for the abuse and making excuses for his spouse in an effort to continue to accommodate her behaviours into his values. Eventually, this individual described a tipping point, when his spouse broached his values in an extreme way, and he realized he had to leave the relationship. Participants in Gregorash's (1993) study also described a similar process of defining and redefining, whereby the men described having to reframe their perceptions of their wives to leave the abusive relationship.

### ***Characteristics of Abuse***

Researchers have also highlighted some specific characteristics of IPA against men, particularly with regards to the types of abuse experienced. Nybergh and colleagues (2016) found their participants were subject to many kinds of physical violence and experienced controlling behaviours in various degrees by their partners. Moreover, women's use of emotional abuse operated to successfully control their partners, whereas physical and sexual abuse methods typically did not achieve a similar result. Emotional abuse was the most common form of control tactic, and involved calling the partner names, belittling them, and humiliating them in both private and public. These women also expressed jealousy and used children as a threat (e.g., threatened to turn them against their fathers or take them away), which were also found to be common control tactics. Similarly, Morgan and Wells' (2016) participants identified three main themes of abuse characteristics: 1) Participants identified as victims of multiple forms of abuse, 2) Participants felt that they experienced controlling abuse, through use of children and isolation; and 3) Participants experienced manipulation through gendered stereotypes of abuse, such as experiencing their partners lying to police that they were being abused by the participant.

These findings have been corroborated in other studies, with men reporting that their female partners utilize numerous power and control tactics, including accessing the men's phone and social media, limiting access to finances, belittling, threatening to make false allegations, restricting access to children, social isolation, and implementing rules that if not followed, would result in further abuse (Park et al., 2020; Sita & Dear, 2020; Walker et al., 2019). Men have also reported experiencing a range of severe and injurious violence, yet the most significant and impactful abuse was the control their female partners exerted over them (Bates, 2019). These control tactics included gaslighting, isolating from supports, limiting basic freedoms, and instilling fear of living with the abuse daily (Bates, 2019).

Fear as a component of men's experiences of IPA has also been investigated by previous researchers. Some men openly discuss their fears of being killed and stalked and described panic about being unable to defend themselves (Brooks et al., 2017). Brooks and colleagues (2017) also found that many of their participants were willing to talk about their fears regarding the abuse, but this discussion was veiled by efforts to retain power and control. For some participants, this was expressed by men denying that they felt fear, and refusing to utilize the term victim, despite their partner's use of violence. Participants also expressed worry of entering future relationships, and related that they believed themselves to be incapable of trusting future intimate partners (Brooks et al., 2017). Further researchers have suggested that although men stated that they were not afraid of physical abuse, many expressed constant fear and anxiety surrounding their partners' ridicule, outbursts, and humiliation tactics (Nybergh et al., 2016). These men changed their behaviour and frequently avoided telling their partners things in an attempt to avoid further emotional abuse, such as being called names or being accused of infidelity. These men further lived in fear of being falsely accused as perpetrators of IPA by their partners (Nybergh et al., 2016). Additional researchers have found that men experience fear regarding the consequences of leaving the relationship (e.g., the partner has threatened to call the police, lie to legal personnel, and/or cease their contact with their children; Sita & Dear, 2020). In other cases, men expressed fear for personal safety and wellbeing, as well as for the safety and wellbeing of their partner and children (Sita & Dear, 2020). Sita and Dear (2020) note that fear is a predominant reason that men decide to remain in the relationship; because the consequences appear worse than the current abuse, the abuser coerces the partner to stay in the relationship. Further research shows that 79% of men who experienced IPA reported no fear, but rather portrayed themselves as calm and rational in the face of severe attacks (Durfee, 2011). However, it is suggested that men might be less likely to admit or identify fear, given the societal and personal pressures surrounding expectations of masculinity (Durfee, 2011).

Sita and Dear (2020) identified an important difference in fear between their sample (i.e., 4 individual cases), and typical studies of women's IPA experiences. Specifically, they found that although their participants experienced physical abuse and reported fear of future abuse, they did not express fear of physical injury or death from potential injuries. They emphasize that this might be unique to their four men, and certainly is not representative of all men in abusive relationships. However, they note that if this experience is common, then the service needs for

men might be different than those for women (e.g., might need to focus more on providing information pertaining to the logistics of leaving the relationship, as opposed to emergency services).

### ***Efforts to Maintain the Relationship***

When men describe their experiences of abuse, they also tend to speak of the efforts that they made to maintain the relationship. For one, this can take the form of contrasting their personal investments with those of their partners (e.g., mentioning the care that they provide to their children, compared to their wives, feeling that their investment in the relationship was not being returned; Corbally, 2015; Gregorash, 1993). Men will also talk of the various ways that they tried to maintain and/or repair the relationship. This can take the form of enduring the abuse without retaliation, apologizing in order to calm their partner, and trying to fulfill their partners' demands, no matter how unreasonable (Park et al., 2020). In addition, men speak of trying to be understanding of their partner's situations, and of rationalizing their behaviour, for example as being due to stress, or a difficult childhood (Park et al., 2020).

### ***Masculinity***

Variables typically associated with masculinity also are commonly reported in the literature surrounding men's experiences of IPA. Gregorash (1993) found that participants felt their relationships were polarized by the struggle for power between the partners and that their wives had total control over them. Migliaccio (2001, 2002) further found that self-reliance (i.e., the men were reluctant to request assistance from others, as they thought it would make them less of a man), stoicism (i.e., men reported an inability to acknowledge both physical and emotional pain, and often minimized their injuries, despite their partners often injuring them severely, and using weapons), and control (i.e., many men struggled to accept that they were not in control of themselves and their emotions, or in control of the overall relationship) were central themes when men described their abuse experiences.

Results from Durfee's (2011) study echo those of Migliaccio (2001, 2002), with participants contextualizing their experience of abuse within a narrative of power and control. Specifically, although participants described various types of abuse perpetrated against them, many men would still portray themselves as dominant. Further, Durfee (2011) found that "the men described their active resistance to the abuse but were careful to note that their actions were not 'abusive' and that they were not the 'abusers'" (p. 316). Many men portrayed themselves as

“rational” and “agentic” and described their use of physical strength as a necessity to protect themselves (p. 326). Last, although the majority of the sample described severe physical and verbal abuse, the majority did not state that they feared their partner (i.e., 79% reported no fear). Rather, many portrayed themselves as calm and rational in the face of severe attacks. Durfee (2011) notes that this “lack of emotional content and matter-of-fact description of events is similar to the stoicism found in the narratives analyzed by Migliaccio (2001)” (p. 328), where men denied feeling emotional or physical pain despite experiencing serious abuse that caused injury. Corbally (2015) found similar results, where men spoke of their direct experiences of abusive behaviours from their partners but not once in the interviews referred to themselves as victims or use this term in any way. Further research suggests that men experience significant shame about their experience (Sita & Dear, 2020). Hogan (2016) notes that this shame and embarrassment is based in men’s belief that they have not met the dominant cultural expectations for men in heterosexual relationships (Hogan, 2016). Many men in Hogan’s (2016) sample spoke of a “desire to maintain a sense of masculinity” throughout the abuse experience (p. 44).

### ***Difficulty Recognizing Abuse***

Men’s difficulty in recognizing that their relationship is abusive has been identified as a concern by multiple researchers. Research into men’s experiences shows that men will report distress at their partners’ behaviour and will recognize changes in their own behaviour but will not label the behaviour as abusive until the patterns were already strongly established (Sita & Dear, 2020). In some cases, it was not until after the relationship had ended that the participants labelled it as abusive (Sita & Dear, 2020). Within this research, participants were more commonly reporting verbal and psychological abuse. Sita and Dear (2020) suggested that this difficulty in assigning a label of abuse to their experience is understandable, given evidence that non-physical abuse is less likely to be viewed as severe (Carlson & Pollitz Worden, 2005, as cited in Sita & Dear, 2020).

### ***Social Influences***

Last, society appears to exert a significant influence on men’s experiences of abuse. Studies indicate that men believe that men’s experiences of IPA are largely ignored, misunderstood, and/or minimized by society (Hogan, 2016; Park et al., 2020). Men who experience IPA report feeling that the abuse they experienced is different, because they are men and thus people perceive them to be either unmanly or undeserving of assistance (Morgan &

Wells, 2016). Brooks et al. (2017) further found that men in their sample cited society as a crucial component of many aspects of their abuse experiences. Participants discussed how difficult it was to disclose their IPA experiences and fear to another person due to the anticipated perceptions of their families and communities. All men spoke of a desire for a safe place for men to talk about their IPA experience and where they can “break the silence of this forbidden narrative” (p. 15).

### **Implications of Abuse**

IPA can have serious physical, emotional, and mental health consequences for men. Although society has a general belief that the abuse that men experience from their partners is trivial (Currie, 1998; Pagelow, 1985), research into the effects of men’s experiences of IPA suggests otherwise.

#### ***Physical Implications***

The most visible aftereffects of IPA include physical harm. This physical harm can be significant, with Stitt and Macklin (1995) reporting that all of the men in their sample had experienced serious forms of physical abuse, including stabbing, teeth being knocked out, scalding, and injury to their genitals. In addition, Carbone-López and colleagues (2006) found that the experience of “interpersonal conflict violence” (i.e., not multifaceted, and restricted to specific violent acts) and “physical aggression” (i.e., not typically sustained or forceful violence) were each associated with two and a half times greater odds of poor self-reported health, compared to men not experiencing any IPA (p. 388). Further, men experiencing systematic forms of IPA (i.e., extensive, multifaceted violence) were more than two and a half times as likely to report an injury disability and more than twice as likely to report an illness disability than men who had not experienced IPA. Coker et al. (2002) analyzed data from the National Violence Against Women Survey (NVAWS) and found significant relationships between men’s experiences of IPA and both poor physical and mental health. Further evidence suggests that men experience female-perpetrated partner-homicide, typically via firearms and knives/blades (Velopulos et al., 2019).

#### ***Psychological Implications***

IPA can also significantly and deleteriously affect men’s mental health. For example, Carbone-López et al. (2006) found that interpersonal conflict violence was associated with nearly twice the odds of serious depression, almost three times the odds of a mental health

disability, over three and a half times greater odds of using an antidepressant, and twice the odds of recreational drug use compared to non-abused men. Further, the odds of serious depression were almost two and a half times greater, while the odds of mental health disability were nearly three times greater. The abuse of power and control in a relationship is also found to be associated with chronic mental illness and increasing psychological IPA scores were strongly associated with current depressive symptoms (Coker et al., 2002).

IPA is further related to increased risk of depression and suicidality. Older men who have been in both physically and non-physically abusive relationships are found to be approximately three times more likely to report severe symptoms of depression compared older men who had not been abused (Reid et al., 2008). Among younger men, those who experienced IPA had lower social and emotional functioning than never-abused men (Reid et al., 2008). Further evidence with men in dating relationships show that they have an increased rate of suicidal ideation and depressive symptoms (Chan et al., 2008). Within these results, depression was found to account for the correlation between suicidal ideation and IPA. Additionally, men who experienced forced and insisted sexual IPA face significant negative implications (Próspero & Fawson, 2010). Men who reported these types of sexual IPA were more likely to have anxiety and somatic symptoms than men who reported verbal or physical abuse.

Further research has focused specifically on the occurrence of PTSD symptoms following men's experiences of IPA. Actual and threatened legal-administrative (LA) aggression against men has been found to be associated with men's mental health symptoms (Berger et al., 2016). Berger et al (2016) note that this effect is likely due to the fact that LA aggression can have serious consequences for men who experience IPA, such as custody concerns, financial instability, and ruined reputations at work and/or in the community (Cook, 2009, as cited in Berger et al., 2016). Furthermore, research suggests that rates of PTSD symptomology range from 10-20% (Coker et al., 2005; Dickerson-Amaya & Coston, 2019). Higher physical or psychological IPA scores were associated with risk of moderate-to-severe symptoms of PTSD (Coker et al., 2005). Hines (2007) also found that experiencing IPA was a significant predictor of PTSD symptoms across all 60 countries involved in their analysis. Further, lower levels of violent socialization (i.e., amount of violence in their country) and higher levels of hostility toward men (i.e., hostile attitudes towards men who experience IPA)

increased the associations between sustaining IPA and experiencing PTSD symptoms (Hines, 2007).

### ***Economic Implications***

In addition to these negative consequences endured by the individual experiencing the abuse, IPA also places a significant strain on the economy. A study performed by Arias and Corso (2005) showed that health care costs for men who experience IPA (i.e., emergency department use, inpatient hospitals, and physical services) associated with each incident of IPA was \$387, the average medical cost was \$83, and the average mental health services cost was \$80. Further, this study found that productivity losses were \$224 for men. Peterson et al. (2018) found that the economic cost of IPA was approximately \$3.6 trillion over a survivor's lifetime. This estimate included \$2.1 trillion in medical costs, \$1.3 trillion in lost work productivity, \$73 billion in legal bills, and \$62 billion in miscellaneous costs (e.g., property loss or damage). They further found that the lifetime cost per individual experiencing IPA is approximately \$103,767 for females and \$23,414 for males (Peterson et al., 2018).

### **Men and Help-Seeking**

#### ***General Help-Seeking***

An entire body of research is dedicated to trying to understand men's help-seeking behaviours; in general, men seem extremely reluctant to seek help. Men around the world have a lower life expectancy than women, and death from coronary heart disease, violence, accidents, suicide, and drug or alcohol abuse is significantly more likely amongst men than women (Möller-Leimkühler, 2003). A recent study links men's low help-seeking to these higher illness and mortality rates (e.g., Hale et al., 2010). Considerable evidence indicates that men are reluctant to seek professional help for both psychological distress (Cleary, 2012; Hoy, 2012; Johnson et al., 2012) and physical distress (Fish et al., 2015; Singleton, 2008; Skeppner et al., 2012). Further, the help-seeking behaviours of men for a variety of issues are at rates far behind those of women (Addis & Mahalik, 2003; Bayram et al., 2003; Möller-Leimkühler, 2003; Nabalamba & Millar, 2007; National Center for Health Statistics, 2010; Pinkhasov et al., 2010; Wang et al., 2007). For example, according to the National Center for Health Statistics (2010) approximately 21% of adult men in 2007 did not visit an emergency department, doctor's office, or utilize home visits as opposed to 12% of women. Further, approximately 24% of men reported that they did not have a usual source of care between the years 2006–2007 compared to 13% of



women (National Center for Health Statistics, 2010). Research also indicates that rates of depressive disorders among men are lower than among women, but men's suicide rates are three to four times higher than women (Crosby et al., 2011; Navaneelan, 2012). This discrepancy is suggested to be partly due to men not seeking and receiving treatment for their depression (Angst & Ernst, 1990; Sierra-Hernandez et al., 2014). As Angst and Ernst (1990) concluded: "women seek help – men die" (as cited in Möller-Leimkühler, p. 3).

Research regarding IPA also indicates that men who experience IPA might engage in alternative behaviours to deal with the abuse they experience or seek more informal sources of help. Brogden and Nijhar (2004) found that, instead of seeking help, the men in their sample tended to manage abuse through alcohol use, passively accepting the abuse, hiding the abuse, physical exercise, spending extra time at work, and leaving the relationship.

### ***Help-Seeking for Intimate Partner Abuse***

A plethora of research indicates this aforementioned reluctance to seek help also applies to men's help-seeking behaviours following IPA. Women who experience IPA are consistently more likely than men to report and seek help for abuse (Barrett et al., 2020; Brown, 2004; Cho et al., 2019; Choi et al., 2015; Coker et al., 2002; Drijber et al., 2013; Lachman et al., 2019; Laroche, 2005; Migliaccio, 2001; Mihorean, 2005; Milligan, 2019) and men tend to deny or down-play their IPA experience when confronted about it by professionals (Corbally, 2015; Durfee, 2011; Migliaccio, 2001). The difficulty men experience in seeking help for IPA might be due to a range of barriers that can be either internal to the man (e.g., shame) or external to him (e.g., reactions of service providers).

### ***Internal Barriers***

**Masculinity and Shame.** Self-report data collected specifically with men who experience IPA elucidate masculinity as a driving factor in men's help-seeking behaviours. Men report finding it difficult to ask for help because they feel humiliated by the experience, and this feeling of shame leads them to silence themselves (Migliaccio, 2001; Walker et al., 2019). The most common reason for this embarrassment and shame was that the men believed that people would "think less of [them] as a man" (Migliaccio et al., 2001, p. 216). Brogden and Nijhar (2004) further found that participants had "difficulty handling their own victim status" (p. 59), and that being unable to confront their women partners in the same way they typically would if a man assaulted them was a large injury to their self-esteem. These men reported struggling

significantly with their victim status, specifically when their self-images were reliant upon traditional patriarchal values. In addition, Brodgen and Nijhar (2004) found that the primary reason why men did not formally or informally report injuries was due to fear of not adhering to traditional images of masculinity. Research also suggests that men believe they should be able to cope with the abuse (Roddy, 2014; Tillbrook et al., 2010) or have enough power in their relationships to stop it (Tillbrook et al., 2010). Machado et al. (2016) corroborate these findings, as their participants related that a major barrier to them seeking help was that they felt shame for being a victim of abuse perpetrated by a woman.

Choi et al. (2015) reported that their sample of men who experience IPA in Hong Kong was reluctant to access help from social workers or to get a consultation with social services as a “help-seeker,” but were very willing to report the abuse to the police as a “crime-reporter.” The authors suggest this was an attempt to protect their masculine identity and avoid losing face. In Simon and Wallace’s (2017) interviews with Chinese men who experience IPA, they found themes that related heavily to Chinese cultural values of masculinity and “macho competence.” Specifically, the more that the men perceived IPA as extraordinary and implausible, the more likely that they were to believe that others had a similar perception. This belief that men’s experience of IPA is not socially acceptable or is incomprehensible consequently limits their ability and desire to disclose the violence, in an effort to protect their masculine identity. Last, the authors found that themes of “macho-competence” and “macho-protection” (i.e., the cultural expectation of Chinese men to be strong and capable to protect their children) presented a significant barrier to disclosing the abuse.

**Fear.** Research studies with men who experience IPA also show that fear is a predominant barrier for men seeking help for IPA. For example, men have reported fear of not being believed (i.e., told that that they must have done something to provoke it or that the woman was retaliating against his own abuse of her; Machado et al., 2016; Tillbrook et al., 2010; Walker et al., 2019), fear that reporting would make the abuse worse (Tillbrook et al., 2010; Machado et al., 2016), and stated that they feared for the impact of reporting on others (e.g., children’s relationship with the perpetrator; Tillbrook et al., 2010).

**Recognizing Their Experience as Abusive.** Another significant barrier to men seeking help is difficulty recognizing their experience as abusive. As noted above, this difficulty is commonplace in men’s IPA experiences, where men will not label the behaviour as abusive until

the patterns were strongly engrained or until after the end of the relationship (Sita & Dear, 2020). Walker and colleagues (2019) further elucidated this process and found that this failure to recognize their experience as IPA can play a significant inhibitory role in men's help-seeking journeys (Walker et al., 2019). Their participants further reported that they felt like their experience was not significant enough to make a report.

### ***External Barriers***

**Lack of Societal Awareness.** Tsui et al. (2010) suggest that lack of public awareness of the occurrence of men's experience of IPA and men's need for help might discourage them from seeking help. Further, Shum-Pearce (2016) found that the men in their sample felt public perceptions were a significant barrier and proposed four main ideas that they wished to make public and believed would be helpful to facilitate help-seeking amongst men who have experienced IPA: "[IPA] does happen to men, it is okay to not feel okay about it, it's okay to ask for help, and it's important to ask for help" (p. 76). Tillbrook et al. (2010) also found that amongst their sample one major facilitator to seeking help for the abuse was publicly available information about IPA; men would be more comfortable seeking assistance if others have been provided information that IPA can also happen to men, because then the men will expect to be believed when they seek help.

**Lack of Services.** An additional issue that presents as a major barrier for men seeking help is the lack of available services. Grassroots movements led by "battered women's" advocates in the 1970s sparked the development of a number of emergency services, particularly for women seeking help for IPA (Hines & Douglas, 2011). Counseling, legal services, outreach, shelter, and other services abounded, and over 600 government-funded shelters for abused women now operate across Canada (Beattie & Hutchins, 2015). However, these initial services were developed primarily to serve women. Furthermore, because feminisms were integral to the impressive effort to recognize women's experiences of IPA and develop services for these women, the philosophy that typically guides IPA services is based on an assumed causal connection between IPA and the patriarchy where men use IPA to dominate women (Dobash & Dobash, 1977). Although this approach can be deemed very fitting to serve many of the women who experience IPA, this means that other people who experience IPA might be denied services (Glass et al., 2009).

Zero federal government-provided or funded shelters in Canada were dedicated to men who experience IPA as of 2014 (Beattie & Hutchins, 2015). However, Cheung et al. (2009) identified some institutional services available to men who experience IPA in Canada, such as Men's Alliance Safe House (MASH Project), Ontario Association of Male Survivor Services (OAMSS), Ottawa Men's Center, The Family of Men Support Society, The Victoria Men's Center, and The Canadian Association for Equality (CAFÉ). These services provide networking supports, victims' services, treatment, shelter, information, and training for men (Cheung et al., 2009). Yet, given the above-mentioned high rates of IPA that men experience at the hands of their partners and the deleterious consequences that can result, the existence of only six specialized services concentrated in only a few areas of the country seems to be a significant disservice to these men. Thus, what we are left with is a plethora of women-focused services that are reluctant to assist, or are even discriminatory towards, men as well as an incredible dearth of services that have been developed primarily to serve men.

Men who have experienced IPA also report in various studies that this lack of available services is a large barrier for them seeking help. Numerous research studies indicate that men are often refused services when they seek help because the providers only help women (Cook, 2009; Migliaccio, 2001; Stephenson, 2009). Thus, an increase in these services might facilitate help-seeking behaviours (Cheung et al., 2009; Shum-Pearce, 2016; Tillbrook et al., 2010; Tsui et al., 2010). Even when men know they need help and try to engage with services, they report that it is difficult to find service providers who understand their stories and are prepared to help (Roddy, 2014). Further, men who experience IPA also relate that these service providers often do not have the proper training and/or attitude to provide beneficial services to them (Tillbrook et al., 2010). Shum-Pearce (2016) further interviewed men who had experienced IPA and asked them for suggestions to facilitate help-seeking amongst young men who also experience abuse. Some participants suggested that services should specifically target abused men, whereas other participants called for a broadening of existing services to incorporate supporting men. These men also clearly related that these services need to be made visible as being inclusive and welcoming, because they believed existing services to be either unsuitable or unfriendly.

**Social Support.** Men report that a large component of their disclosure and help-seeking journey is influenced by the responses that they receive from friends and family. Findings from qualitative research suggests that the responses that men receive are varied: some report being

met with shock and surprise, others were not believed, or found that friends and family minimized the abuse, some were blamed, while others received understanding and sympathy (Bates, 2019; Walker et al., 2019). Further quantitative research shows that feeling like one belongs socially is related to greater likelihood of seeking help from friends or neighbors (Barrett et al., 2020). However, social belonging was not found to be related to increased help-seeking from other sources (i.e., formal sources; Barrett et al., 2020).

**Help-Seeking Experiences.** An abundance of research indicates that even when men are able to locate these minimally available services, the responses they receive from service providers can be unhelpful and even harmful. One common response that men report is that service providers tend to side with their female partners (i.e., the abuser) and accuse them of being the abuser and even wrongfully arrest them (Bates, 2019; Brogden & Nijhar, 2004; Cook, 2009; Douglas & Hines, 2011; Eckstein, 2009; Hines et al., 2007; Machado et al., 2017; Migliaccio, 2001; Stephenson, 2009; Tsui, 2014; Walker et al., 2019). Research into men's experiences also shows that service providers minimize men's experience of abuse, such as by saying that the men deserved it and suggesting that men cannot be victims (Bates, 2019; Brogden & Nijhar, 2004; Douglas & Hines, 2011; Eckstein, 2009; Migliaccio, 2001; Stephenson, 2009; Tsui, 2014). Furthermore, many men report being ridiculed and laughed at when they seek services (Bates, 2019; Cook, 2009; Douglas & Hines, 2011; Hines et al., 2007; Machado et al., 2017; Walker et al. 2019). Other men who experience IPA have described experiencing general unhelpfulness and incompetence from professionals upon seeking services (Brogden & Nijhar, 2004; Douglas & Hines, 2011; Entilli & Cipolletta, 2017; Machado et al., 2016; Machado et al, 2017; Stephenson, 2009; Tsui, 2014).

Negative help-seeking experiences can have a number of deleterious effects for men who experience IPA. For example, Dobash and Dobash (1984) suggest that these negative responses can leave them feeling isolated and thus vulnerable to further IPA. Further, Douglas and Hines (2011) found that, for each additional negative experience with help-seeking that a man reported, their odds of meeting the cut-off for PTSD increased 1.37 times. Conversely, each additional positive help-seeking experience correlated with a 40% decreased likelihood of having abused alcohol in the previous year. Further research shows that people who encounter negative attitudes when seeking help to leave an abusive relationship tend to remain in the abusive situation longer (Eckstein, 2009; Hollenshead et al. 2006; Koepsell et al., 2006).

### ***Who Men Seek Help From***

Another body of research focuses on what types of sources men seek help from, when they eventually make that decision. For one, anonymous sources appear to be a particular facilitator for men seeking help. Tsui (2014) found that the Internet specifically was a popular source of help, due to its flexibility and anonymity, and Shum-Pearce (2016) found that men preferred anonymous methods of initially contacting help-resources before making the decision to attend in person. Ansara and Hindin (2010) found that the most common services men sought help from were health professionals and the police; however, who they disclosed to also varied according to the perceived severity of the abuse, with men seeking formal sources of help (e.g., psychologists) for more serious abuse and informal sources of help (e.g., family members) for less serious abuse. Machado et al. (2017) also found that the severity of the abuse predicted the formality of the help sought. Overall, informal sources of help, such as family and friends, appear to be the most preferred sources of help (Eckstein, 2009; Machado et al., 2016; Tsui, 2014). These informal sources were chosen because the men already had established, trusting relationships with these people (Eckstein, 2009; Tsui, 2014). Tsui (2014) found that informal sources helped to mediate the shame and embarrassment men felt about their abuse. In addition, and as noted above, Choi et al. (2015) found an overall preference for seeking help from police officers as opposed to health professionals (e.g., social workers), which was thought to be due to the men's efforts to retain a masculine identity by presenting as "crime reporter" as opposed to a "help-seeker."

### ***Reasons for Seeking Help***

Few researchers have studied men's expressed reasons for eventually seeking help for IPA. As mentioned above, the severity of the abuse appears to play a significant role in the type of help that men seek (Ansara & Hindin, 2010; Machado et al., 2017), and thus there is assumably a crucial point at which the abuse gets serious enough and prompts men to seek help. Eckstein (2009) further found that men report disclosing and/or seeking help for the abuse because of a desire for emotional release. It is important to note that addressing this gap was one area of focus of my dissertation. Other researchers have reported that men will seek help for personal and relational difficulties which they struggle to cope with on their own (Roddy, 2014). Specifically, men have reported complex feelings of guilt, anger, loneliness, and isolation, alongside continued abusive behaviours, even after leaving the relationship (Roddy, 2014). Men

stated that it was the combination of these feelings and experiences that increased their distress to a level that was unbearable thereby resulting in them seeking help, (Roddy, 2014).

### ***Summary***

As reviewed above, there have been numerous attempts to theorize about the process that men go through to seek and receive help for a variety of concerns. One of these concerns includes men's experiences of IPA. Research suggests that this is multifaceted process, that is influenced by a variety of factors. However, there has been no research attempts to develop a comprehensive theory regarding the process that men go through to seek help for this abuse specifically. As a result, my goal through this dissertation was to fill this gap, by using a grounded theory methodology to develop this theory.

### **Theoretical Process of Men's Help-Seeking**

The aim of the first study of my dissertation was to develop a theory regarding the process of men's help-seeking for IPA. As such, I did not review the literature regarding attitudes and service provisions until after data gathering and analysis had been completed. This was done in order to maintain the integrity of the model, and to ensure that I was not building the theory influenced by previous research. This is in line with Charmaz's (2014) recommendations, where she suggests that one conduct an initial review of the literature review prior to conducting one's research (as done above), in order to initiate inquiry and minimise presumptions, but to cease reviewing the literature during data collection and analysis. Thus. the following literature was reviewed after my results had been completed. This literature describes previous theoretical research surrounding men's help-seeking, and my developed theory will be examined in the context of this research in the discussion section. My literature review confirmed that no previous theoretical work on this topic exists. However, there exists two areas of theory that might be relevant for men who have experienced IPA: general theories of help-seeking, and theories of women's help-seeking for IPA. Both areas of theory are reviewed here.

### ***Theories of General Help-Seeking***

**The Health Belief Model.** This model hypothesizes that several factors influence people's likelihood to engage in health-related behaviours: a) perception of susceptibility to contracting the illness, or to the illness itself, b) belief that the illness might have severe consequences or might cause significant interference in life, c) belief that the help-seeking will be beneficial, and d) perception of minimal barriers to help (Henshaw & Freedman-Doan, 2009).

Demographic variables are thought to be significant for all of these factors (Henshaw & Freedman-Doan, 2009). Cues to action, which are incidents that remind the individual of the illness threat, are an important fifth factor in encouraging help-seeking (Henshaw & Freedman-Doan, 2009). Henshaw and Freedman-Doan (2009) note that Rosenstock et al. (1988) further incorporated facets of social cognitive theory (Bandura, 1977) to this model and suggested that one's belief in their ability to influence health outcomes (i.e., self-efficacy), is also important. For example, believing one is capable of healing is also crucial in determining whether someone will seek help – if one does not believe help will make a difference, one will not seek it out (Henshaw & Freedman-Doan, 2009).

This model has been critiqued for its disconfirmability (Ogden, 2003), and its limited ability to predict long-term health-related behaviours (Kirscht, 1983). With regards to the long-term, Henshaw and Freedman-Doan (2009) note that the factors relevant to initiating treatment (as noted in the model) might be different from those that predict later treatment engagement and adherence, and thus, they should be clearly distinguished from one another. Within the Health Belief Model, help-seeking behaviours can be “facilitated by accurate information to answer these basic decision-making questions: a) severity: when are my symptoms “bad enough” to seek professional help? b) benefits: does professional help increase my chances of feeling better soon? c) barriers: are the financial, emotional, or other costs of seeking professional help worth the possible benefits? and d) self-efficacy: am I capable of making the changes necessary to improve how I feel?” (Henshaw & Freedman-Doan, 2009, p. 434).

**The Theory of Planned Behaviour.** This model was originally developed within the context of help-seeking for breast cancer (Ajzen, 1991) to generically explain people's likelihood of performing behaviours. It highlights intentions as being a predominant factor in undertaking a given behaviour, as intentions are thought to encapsulate the motivation necessary to influence a behaviour (Ajzen, 1991). Intentions are indications of how much effort people are willing to engage in to perform a behaviour (Ajzen, 1991). Further, the Theory of Planned Behaviour suggests that one's attitude toward a behaviour is an integral predictor of intention to engage in that behaviour (Ajzen, 1991). Both subjective norms (i.e., an individual's view of the personal social reward or consequences of engaging in a behaviour) and perceived behavioural control (i.e., a person's conception of difficulty or ease in enacting a behaviour), are also important components of this model. The theory posits that behavioral choices are largely determined by



these aforementioned variables, indicating that there is a rational process behind decisions to seek help (Ajzen, 1991).

This model has been found to have explanatory power, in the context of women's help-seeking for breast-cancer (Hunter et al., 2003). As well, Smith et al. (2008) tested this model as a theoretical basis for understanding men's psychological help-seeking behaviours. Results showed that attitudes towards psychological help mediated the relationship between help-seeking intentions and ideologies of traditional masculinity. Overall, Smith et al. (2008) suggested that the Theory of Planned Behavior might presents as a useful model to help understand men's help-seeking for psychological concerns.

**Network Episode Model.** This model (Pescosolido, 1992; Pescosolido et al., 1998), emphasizes the importance of the health care system and social networks in utilization of services. It makes no single assumption about how clients access help, but rather focuses on the dynamic processes that underlay the use of services (Pescosolido, 1992). This model hypothesizes that clear, independent choice to seek help is one of many ways that clients seek help, alongside coercion and passive, indirect pathways to help (Henshaw & Freedman-Doan, 2009). This model also "targets the importance of social influence (exerted through 'community' social networks) on when, how and if individuals receive care" (Pescosolido et al., 1998, p. 276).

This social influence can assist the individual in their independent choices to seek help or can take the decision out of the individual's control, such as through forced hospitalization (Pescosolido et al., 1998). Further, help-seeking is a process that involves a series of decisions, rather than a single, planned choice. People often continue to seek advice regarding a problem from a variety of informal sources of support (e.g., family, coworkers, friends); ethnic/traditional healers (e.g., clergy, spiritual leaders); collateral service providers (e.g., physicians, teachers); and mental health professionals until the issue is resolved, or there are no remaining options. Pescosolido et al. (1998) notes that it is also important to acknowledge that how person begins their help-seeking journey does not necessarily cement the remainder of their help-seeking trajectory. For example, he notes that some individuals who are coerced might eventually "understand" the importance of care, while others who sought help by their own volition, might leave with negative perceptions of the help they sought (Pescosolido et al., 1998).

**Help-seeking Model.** Next, Cramer's (1999) Help-seeking Model indicates that: 1) Individuals are more likely to seek counselling when they are highly distressed and hold positive

attitudes towards counselling, 2) Distress is likely to be increased when people have impaired support networks and conceal their struggles from others, and 3) Individuals who conceal their distress are more likely to have negative attitudes towards support services and have impaired support networks.

**Information-Processing Model.** This model as applied to individuals' decision to seek professional help (Vogel et al., 2006), provides much insight into the journey towards accessing help. Vogel et al. (2006) suggested that help-seekers follow a 4-step process. In step 1, individuals encode and interpret internal and external cues. Vogel et al. (2006) notes that one of the main factors during this step is the personal significance that a person places on a symptom, and what it means to them. In step 2, individuals produce behavioural options based on previous interpretations and their personal goals (Vogel et al., 2006). First, they must decide if there is a problem that needs addressing and that there is something that can be done about the distress (Vogel et al., 2006). Vogel et al. (2006) discussed Cameron et al.'s (1993) findings that the existence of a novel symptom alone was not enough, but the individual had to recognize that their symptoms were serious enough to require help. If a symptom is then interpreted as requiring attention, then options are generated according to that person's goals (Vogel et al., 2006).

In step 3, individuals choose a response from the options in step 2 (Vogel et al., 2006). This process involves evaluating the potential responses, with a significant focus on what the outcome will be if that behaviour is chosen (Vogel et al., 2006). Namely, it is here that individuals increasingly evaluate the pros and cons of their generated options and decide regarding the best course of action (Vogel et al., 2006). The individuals are thought to choose the response that is perceived to have the greatest benefit and the least cost (Vogel et al., 2006). Vogel (2006) noted a number of important costs that people perceive related to seeking help, including the negative expectations that people have about therapy, fear of disclosing personal or emotional information, and fear of stigmatization, all which might have to be addressed with service-seekers in order to facilitate help-seeking.

Last, step 4 involves evaluating and considering the outcome of the chosen behaviour and drawing on these evaluations in decisions about next steps (Vogel et al., 2006). Vogel (2006) noted this as an important factor in understanding the help-seeking process, as individuals tend not to choose professional services (e.g., therapy), as a first choice (Hinson & Swanson, 1993; Lin,

2002, as cited in Vogel, 2006), but rather following attempts with other informal courses of help (Wills, 1992, as cited in Vogel, 2006). Thus, seeking help from professionals might only occur after people have utilized other services and not found them helpful, and the consequences of not seeking professional help have increased (Vogel et al., 2006).

**Prototype Willingness Model.** This model (Gerrard et al., 2008) is related to other dual-processing models in that it assumes that there are two types of decision making involved in health behavior (i.e., one based more on heuristics and emotion, and another based more on deliberative, systematic reasoning; Gerrard et al., 2008). Originally, this model was developed to explain adolescents' risk-taking behaviours (Gerrard et al., 2008), but has since been applied to understanding help-seeking decisions (Hammer & Vogel, 2013). The Prototype Willingness Model suggests that there is a deliberative, rational path through which people intentionally engage in behaviours, similar to the pathway described by reasoned-choice models (attitudes and social norms predict intention, which in turn predict behavior; Hammer & Vogel, 2013). The second path is an image-based path, influenced by social reactions, that impacts behavior through willingness (Hammer & Vogel, 2013). The social reaction path involves reactive, spontaneous decisions, rather than systematic logic. Namely, a willingness (as opposed to a planned intention) to engage in the behavior, when given the right set of circumstances (Hammer & Vogel, 2013).

Within this model is the assumption that willingness might be a more salient factor than intention for help-seeking decisions (Hammer & Vogel, 2013). Much like intention, willingness is theorized to be influenced by attitudes and social norms (Hammer & Vogel, 2013). However, according to this model, the prototype that an individual associates with a given behavior (e.g., the perception of the common person who seeks psychological help) is hypothesized to be an additional influence on one's willingness to engage in that behavior (Hammer & Vogel, 2013). The Prototype Willingness model posits that individuals perceive that if they perform the identified behaviour, they will then assume the image (i.e., prototype), associated with that behaviour (Gerrard et al., 2005, as cited in Hammer & Vogel, 2013). As such, the perceived favourability of the prototype will influence people's willingness to engage in the behaviour (Hammer & Vogel, 2013).

When studied empirically, Hammer and Vogel (2013) found that the social reaction path— where help-seeking attitudes, norms around help-seeking, and the individual's prototype

of what typical help-seeking looks like, was linked with help-seeking decisions through the mediating role of willingness. Willingness independently explained a significant portion of the variance in help-seeking decisions beyond what was explained by the reasoned path (Hammer & Vogel, 2013). Moreover, whereas both intention and willingness were significantly related to help-seeking decisions, when both paths were simultaneously modeled, intention failed to account for unique variance in help-seeking decisions, while the indirect effects of attitudes, social norms, and prototype were likewise fully accounted for by the social reaction path (Hammer & Vogel, 2013). In sum, results indicated strong support for the dual-process model of help-seeking and indicated that more positive attitudes and social norms predict both greater intention and willingness to seek help.

### ***Theories of Help-Seeking for IPA***

Currently, there have been no theories developed to explain men's help-seeking for IPA. However, a number of theories have been posited and/or applied to understand women's help-seeking for IPA. As such, these theories will be reviewed here. Burgess-Proctor (2012) provided a thorough review of the help-seeking theories for IPA, and thus the review below is based on their article.

**Learned Helplessness Model.** This model (Walker, 1979) has long been cited as a theoretical model for understanding women's decisions to seek help for IPA. Walker (1979) argued that severe IPA creates "learned helplessness" in those who experience IPA, which then manifests in them remaining in the abusive relationship. This theory suggests that efforts to seek help will decline as violence severity increases, and as the individual's resulting "helplessness" becomes more pronounced. Although Walker (1979) was initially praised for their effort to place help-seeking for IPA within a theoretical framework, this model has been criticized for pathologizing women in abusive relationships, and for perpetuating a stereotype of women in abusive relationships as passive and meek (Gondolf & Fisher, 1988). Moreover, several studies depict evidence that disproves learned helplessness theory (see Bowker, 1983 and Pagelow, 1981, as cited in Burgess-Proctor, 2012).

**Survivor Model.** The Survivor Model (Gondolf & Fisher, 1988) was developed in contrast to Walker's (1979) Learned Helplessness Model. The Survivor Model can be used to examine how abuse severity influences help-seeking and predicts that increasing abuse severity in combination with amplified anti-social behaviour results in increased help-seeking (Burgess-

Proctor, 2012). This framework emphasizes that women who experience IPA actively desist and combat their abuse by utilizing various avenues of help (Burgess-Proctor, 2012). Although viewed by theorizers as an advancement in help-seeking theorizing, this model has been criticized for being limited to the individual and interpersonal levels, leaving minimal opportunity to examine the influence of broader social systems (Burgess-Proctor, 2012).

**Barriers Model.** In response to this call for a recognition of the influence of broader, societal factors, Grigsby and Hartman (1997) developed a theoretical model known as The Barriers Model. This model aims to understand help-seeking behaviours as occurring amongst individual- and structural-level factors (Burgess-Proctor, 2012). This model centers women amongst four concentric circles, where each circle represents a subset of barriers that might impede the woman's safety. These barriers include environmental, socialization, gender role expectations, and mental health difficulties stemming from IPA and/or childhood abuse/neglect experiences (Grigsby & Hartman, 1997, as cited in Burgess-Proctor, 2012). Primarily, this model has been used to determine appropriate intervention strategies for therapists, and thus has been critiqued as to its utility to actually explain help-seeking behaviours (Burgess-Proctor, 2012).

**Behavioural Model of Health Care Utilization.** This model (Andersen, 1995) is a further well-known theoretical model, originally developed with the goal of understanding why certain segments of the population were more likely to access formal health services, compared to others. The model conceptualizes predictors of help-seeking into three categories: 1) predisposing characteristics (i.e., relatively fixed features of an individual which make them more inclined to utilize health care services, such as generation and race), 2) enabling resources (i.e., resources that are not necessarily fixed, and can increase or decrease the likelihood of health care utilization, such as having health insurance, or proximity to health care resources, and 3) need-based factors (i.e., variables that are related to the degree to which an individual needs health care services. These can be both objective measures or subjectively perceived need). This model argues that the greater objective and subjective need (i.e., greater symptom severity), the more likely an individual is to access health care (Peter et al., 2019). Although originally developed to understand gender health care seeking, this model has been utilized as an explanatory theory for help-seeking for IPA (Fleming & Resick, 2017; Klopper et al., 2014; Peter et al., 2019). Fleming and Resick (2017), and Klopper et al. (2014) found that the positive association between symptom severity and health care utilization (a core assumption of this

model), has received mixed support. A third study, conducted by Peter et al. (2019), examined three categories of variables (predisposing characteristics, enabling resources, and need-based factors) in the prediction of completion of a multisession mental health evaluation among women who experience IPA. Their results indicated that the Behavioural Model of Health Care Utilization, specifically the predisposing and enabling resources segments, are useful in helping us understand help-seeking behaviours. However, their results indicate that the assumption inherent in need-based factors (i.e., that symptom-severity will predict health care utilization), is more complex. Rather, symptom severity might function in a non-linear fashion, with regards to mental health care utilization. A curvilinear relation may better explain the association between symptom severity and access, in that some amount of psychological distress may be associated with the initiation of utilization, but higher levels of distress may serve as a barrier to maintained help-seeking.

**Rational Choice Model.** This model (Kingsnorth & MacIntosh, 2004) suggest that women's decision to seek help is based on a "complex decision-making process in which they seek to weigh the costs and benefits of involving criminal justice system officials in their lives" (Kingsnorth & MacIntosh, 2004, p. 322, as cited in Burgess-Proctor, 2012). Despite the obvious contribution of this model to theorization about help-seeking, it has still been critiqued as lacking the theoretical complexity necessary to understanding help-seeking (Burgess-Proctor, 2012).

**Cognitive Process Model.** The Cognitive Process Model (Liang et al., 2005) is said to be the most comprehensive approach to theorizing about women's help-seeking for IPA (Burgess-Proctor, 2012). Liang and colleagues (2005) post that help-seeking for IPA occurs in three stages, where women: 1) recognize their abusive relationship as a problem, 2) make the decision to seek help, and 3) identify the appropriate source of help. At each of these time points, the individual must decide whether to continue to discontinue help-seeking (Liang et al., 2005). Liang et al (2005) further identified various individual (e.g., prior abuse experiences), interpersonal (e.g., comfortability relating to others), and sociocultural (e.g., cultural understandings of gender roles and patriarchy) factors that also influence women along their help-seeking journeys. Burgess-Proctor (2012) suggests that the Cognitive Process Model has two primary strengths over previous models: it attends to structural forces and acknowledges the role that individual trauma histories might play in seeking help. However, Burgess-Proctor

(2012) critiqued the model's lack of specificity regarding the specific mechanisms through which trauma histories might influence decisions to seek help.

**Feminist Pathways Theoretical Model.** Burgess-Proctor (2012) then investigated the utility of the Feminist Pathways Theoretical Model, as a model for understanding help-seeking behaviours. The Feminist Pathways Model is a developmental model, and takes into account the influence of cultural, structural, and individual factors on the offending behaviours of women and girls (Burgess-Proctor, 2012). Burgess-Proctor's (2012) research demonstrated that childhood trauma informed later decisions to seek help, typically by inhibiting help-seeking (especially help-seeking from professional sources), though in some cases it actually facilitated help-seeking. Furthermore, Burgess-Proctor (2012) concluded that help-seeking might best be conceptualized as a trajectory of behaviour, similar to criminal offending; trauma in childhood can influence help-seeking trajectories for those who later experience IPA in adulthood. Once these pathways are established, individuals might continue along this path until an experience compels them to engage in a different help-seeking trajectory (Burgess-Proctor, 2012). For example, Burgess-Proctor (2012) notes that when childhood trauma inhibits help-seeking, a woman may avoid formal services until a particular turning point results in a decision to utilize alternative help-seeking trajectories (e.g., police or other formal supports).

**Intimate Partner Stigmatization Model.** This model was developed by Overstreet and Quinn (2013) and posits that three types of stigma present as barriers for those seeking help for IPA. Cultural stigma involves societal beliefs that oppress and delegitimize those who experience abuse. Stigma internalization refers to the degree to which people internalize and believe negative stereotypes about people who experience IPA. Last, anticipated stigma refers to an individual's concern about what will happen once others are aware about the IPA.

### ***Summary***

In sum, researchers have worked to understand the theoretical processes behind help-seeking for IPA. Although these theories, particularly Liang and colleagues' (2005), are explanatory and descriptive, they are not developed from the lived experiences of those who have experienced IPA. It is important to develop theories which are grounded in the target populations' experiences for a number of reasons. The term, "nothing about us without us" (Charlton, 2000, p. 1) was developed with regards to disability activism in the 1990s but has come to be widely used to communicate the idea that "nothing should be decided without the full

and direct participation of members of the group most closely affected” (Byrne et al., 2013, p.2). In this way, we see that the voices of those who have experienced IPA have been largely left out of the previous theoretical literature surrounding help-seeking for IPA. This both goes against my position as an anti-oppressive researcher and is contraindicated in light of Byrne et al.’s (2013) call. Furthermore, theories developed from lived experiences are said to provide greater richness and depth to our understanding of the phenomenon under study, compared to those which are not (El Hussein et al., 2013). Based on this information, the previously reviewed theories are necessarily limited in their ability to describe the depth and nuances inherent in the help-seeking process. Thus, a crucial next step in the theoretical literature surrounding IPA help-seeking would be to develop a theory grounded in individuals’ help-seeking experiences. Furthermore, what is missing holistically from this research base, is the intersection between the two constructs – there is currently no developed or postulated theory for understanding *men’s* help-seeking specifically for IPA. Namely, we do not yet know if the above-reviewed theories can apply to men and IPA. As such, through Study 1 of my dissertation I aimed to fill this gap, by developing a theory from the ground up, in order explain, predict, and understand men’s help-seeking for IPA. The fit between the theories reviewed above and my own theory will be thoroughly examined in the discussion section.

## **Service Providers’ Responses to Men Who Experience IPA**

### ***General Service Providers’ Perceptions***

The majority of the research investigating service providers’ perceptions of men who have experienced IPA depict bias against this population. Police officers are one type of professional whose perceptions have been heavily researched, particularly with vignette studies. Research to this effect suggests police officers rate men who experience IPA as more in control of, and responsible for, their actions than women who experience IPA, and that the credibility and responsibility of the perpetrator and experiencer also influences the likelihood that men who perpetrate IPA get arrested, but not women (Finn & Stalans, 1997). Furthermore, police officers are more likely to suggest arrest or call the police for men who perpetrate than women (Cormier & Woodworth, 2008; Finn & Stalans, 1997), and to believe a man will be convicted of assault than a woman (Cormier & Woodworth, 2008). Police officers have also been found to perceive abuse perpetrated by a man as more serious, dangerous, and harmful, than abuse perpetrated by a woman (Finnegan et al., 2018; Russell, 2018). In addition to these hypothetical vignette



scenarios, Hamilton and Worthen (2011) analyzed a quantitative dataset where police officers completed a mandated checklist after responding to a domestic dispute to explore how gender might affect police decisions to arrest in IPA situations. They found that an arrest was more likely in heterosexual couples when the suspect is a man (woman being the one abused) than when the suspect was woman, despite the finding that women suspects were more likely to have caused visible injury to their partner and to have threatened with a weapon.

Research has also investigated general groups of service providers (e.g., mental health professionals, shelter workers, IPA resource center workers, victim service workers). A vignette study indicated that professionals rated violence perpetrated by a man as more coercive and intentional and violence perpetrated by a woman as more expressive; despite similar types of violence, IPA perpetrated by a woman was assumed to be less serious than IPA perpetrated by a man (Hamel et al., 2007). Further, Hanna (2015) found that health-service professionals exhibited overall negative attitudes toward heterosexual men who experience IPA, as measured by the Domestic Abuse Attitude Scale (20 items used to measure attitudes toward men who experience IPA). The only quantitative study out of those reviewed thus far in this section that found positive perceptions was conducted by Valgardson (2014). Their results show that, in general, service providers at IPA resource centers are supportive of those who experience IPA regardless of gender. In addition, when participants were provided two identical IPA vignettes, the gender of the abuser or experiencer did not influence how the service provider perceived the incident. However, the author did note that self-selection bias might have played a role in the results, such that they had a high level of non-response from resources centers, and thus those who held negative stereotypes towards men who experience IPA or did not have experience working with them, might have chosen not to participate in the study.

**Individual Differences.** To further understand these service providers' perceptions of men who experience IPA, researchers have worked to identify different factors that might influence a professional's responses to men who experience IPA. This research has revealed some important individual differences that might influence perceptions of men who experience IPA.

Valgardson (2014) found that service providers who had more training felt more capable in assisting men who experience IPA, and also were more likely to report that men might not be able to deal with the pressure of IPA on their own. This indicates that greater levels of training

might assist in increasing service providers' acknowledgement that men need assistance.

However, Hanna (2015) also found that older, more educated, and more experienced individuals showed a higher level of negativity towards the men who experience IPA in general, and that male professionals exhibited more negative attitudes to men than female professionals. These findings indicate a discrepancy in the literature, perhaps pertaining to generational differences.

In addition, Zeinert (2017) looked at clinician's perceptions of men who experience IPA and found that participants who had greater endorsement of IPA myths perceived the scenario to be less serious and blamed the individual who experienced IPA at greater rates than those who endorsed fewer domestic violence myths. Further, Zeinert (2017) found that age, years of experience, amount of experience, and type of educational degree all impacted perceptions of men who experienced IPA. Specifically, participants with a Psy.D. excused the perpetrator much more when the experiencer was a man (perpetrator was a woman) than when the experiencer was a woman (perpetrator was a man), compared to those with other degrees. Participants with a Master's degree showed similar trends, whereas participants with a Ph.D. did not differentially excuse the perpetrator. Participants with a Psy.D. and with a Master's degree viewed the situation relatively the same, in that greater endorsement of domestic violence myths was related to greater minimization of the seriousness of the violence in the scenario and lesser endorsement of these myths related to lesser minimization of the seriousness. Further, participants with a Ph.D. minimized the seriousness of the situation more so than participants with either a Master's degree or a Psy.D. on both levels of domestic violence myth endorsement, high or low. Further, participants who had treated a low percentage of clients affected by IPA excused the perpetrator at approximately the same rates when the individual being abused stayed compared to when they left. However, participants who had treated a higher percentage of clients affected by IPA excused the perpetrator more so when the individual being abused stayed in the relationship. Last, when the sex of the individual being abused varied, younger participants viewed the man who experienced IPA as less blameworthy than older participants.

### ***Counsellors who Specialize with Men who Experience IPA***

Given the unique experiences that each sub-set of service providers have, I made the decision to narrow the focus of my dissertation to center on counsellors. This decision was influenced by a variety of things, most salient being my personal investment in counselling and competent counselling (i.e., as a clinical psychology graduate student), as well as based on the budding research in the area of counselling competence with men who experience IPA and the perspectives of counsellors regarding this population. Moving forward, my focus will be on counsellors (i.e., any service-provider who provides counselling as part of their professional position), and the term service provider will be used to describe any non-counsellor who works in a helping capacity.

**Perceptions of the Issue.** There is a growing body of literature aimed at understanding the perspectives of counsellors who work with men who have experienced IPA. Research depicts that counsellors hold both positive and negative attitudes towards this population. Furthermore, at present there is a complete absence of health-care-based interventions for men who have experienced IPA (Tarzia et al., 2020). As a result, there have been efforts made to speak with those who provide services to this population, in order to ascertain ways to improve service provisions and/or to tailor them to the specific needs of these men. Within this literature, counsellors discuss varied perceptions of this population.

There is a subset of research indicating that some counsellors hold prejudicial attitudes towards men who experience IPA. Results show that psychologists rated abusive behaviours perpetrated by a man as more severe and more abusive than the same behaviours perpetrated by a woman, independent of the gender of the psychologist (Follingstad et al., 2004). Further, Zeinert (2017) looked at psychotherapists' (i.e., licensed marital and family therapists and clinical psychologists) perceptions of men who experience IPA and found that clinicians were more inclined to blame the person experiencing the abuse and excuse the perpetrator when the man was experiencing IPA, than when the woman was.

Research by Lawrence (2012) suggests that counsellors might more easily assign the term "perpetrator" to men not to women. This was attributed to women's aggressive behaviour being viewed as unintentional, but rather reactive, which is thought to be unlike men who are perpetrators (Lawrence, 2012). The language surrounding their experience and the therapists' beliefs regarding the cause of men experiencing IPA at the hands of their partner, appear to be

biased towards belief of, and support for, the women partners (Lawrence, 2012). Further, counsellors have been found to express divergent views from those of the individuals they work with; some reported that although the men they worked with were subjected to abusive behaviours that matched descriptions of IPA, they are different from women because they are not overwhelmed by fear or controlled by their partners and trapped in the abusive situation (Tillbrook et al., 2010). This was in stark contrast to the men's self-reports, where a number of men reported fear and intimidation as well as being controlled by their partners (Tillbrook et al., 2010). At times, it has also been suggested that counsellors "enter their practice with a distorted vision of [IPA], a relative lack of sensitivity to husband abuse, a bias in favour of wife abuse, lack of skills to deal effectively with abused husbands, and a relative inadequacy to deal with this type of problem in general" (Sarantakos, 1999, p. 244).

There is also a literature base suggesting that counsellors hold positive perceptions and supportive attitudes towards men who experience IPA. Some research indicates that counsellors note the lack of societal recognition of this issue, and regard it as a significant barrier for men seeking help (Hogan et al., 2012; Molloy, 2017; Wallace et al., 2018). Counsellors also note that shame of IPA experiences and gender expectations arise as further barriers to men recognizing and accepting their experience (Hogan et al., 2012; Molloy, 2017; Wallace et al., 2018). This in turn can present significant challenges within the counselling process (Hogan et al., 2012). As a result, counsellors have emphasized the importance of increasing societal recognition and public awareness that men can also experience IPA and related that these men deserve the same care and attention as women (Molloy, 2017). Furthermore, Lawrence, (2012) found that a subset of their participants utilized an integrated relational perspective and avoided either/or approaches that allocated blame. Rather, these counsellors worked to hold both partners responsible for their choices and attempted to understand the motivations of both genders. Service providers have also been found to be able to identify and recognize many of the same barriers and facilitators to seeking help that are recognized by the men themselves and their families, and report that they believe that IPA against men is a serious issue (Tillbrook et al., 2010).

**General Competence.** Despite the relatively mixed perceptions of counsellors regarding this issue, researchers have worked to elucidate what changes might be necessary to encourage improved, more competent therapy services to those who experience IPA.

Roddy (2014) used grounded theory to investigate men's and women's experiences with counselling at IPA agencies. Results showed that although women progressed through a multi-stages counselling process (e.g., exploration of previous experiences, trauma-focused treatment), men typically had fewer resources available, and often were provided more short-term work, focused on resolving current issues. Despite this difference, results showed that for both men and women, finding a counsellor who understood IPA specifically was incredibly helpful to establishing trust in the agency and the counsellor. Roddy's (2014) study showed that men can experience significant benefits from counselling for IPA. These men reported that they found it beneficial to just talk about their experience. An additional important aspect of the counselling was feeling that the counsellor genuinely cared for them and was concerned about their wellbeing, provided them space to speak and be understood, and believed their story. This was in contrast to participants' other experiences, where they had felt like counsellors were not present and lacked empathy. Oftentimes the usefulness of counselling was judged by the man's feelings of connection and being cared for by the counsellor.

Based on this research, and additional interviews with professional counsellors, Roddy and Gabriel (2019) developed a competence framework for providing services for both men and women who have experienced IPA. Competence in working with different populations is a mainstay of therapeutic work (Fairburn & Cooper, 2011). It "refers to the degree to which a therapist implements therapy components skillfully, adapting as necessary based on the needs of a given client" (McHugh & Barlow, 2010, as cited in Goldberg et al., 2020, p. 2). Competence can refer to a variety of situations, including competence with specific therapeutic orientations (e.g., cognitive behavioural therapy), client demographics (e.g., sexual orientation), or presenting concern (e.g., IPA). Providing therapy to clients who are outside of one's scope of competence can negatively affect the client's treatment (Wise, 2008), and in general is considered to be an ethical concern that should be avoided (CPA, 2017).

Working with a therapist who does not understand the nuances of IPA can pose numerous difficulties for both the therapist and the client (Roddy, 2014). Clinicians globally have indicated the need for counsellors to have specialized knowledge and techniques when working with people who experience IPA (Dutton, 1992; Walker, 1994; Sanderson, 2008, as cited in Roddy and Gabriel, 2019). As noted above, Roddy and Gabriel (2019) provided a framework for understanding what competencies are required when working with this population.

Roddy and Gabriel (2019) described this competency framework in practice. They note that the first phase of counselling involves building trust in the therapeutic relationship. Due to the nature of their abusive relationship, and the manipulation and denigration often involved, clients can have a lack of trust, and increased wariness (Sanderson, 2008). This can include difficulties trusting the clinician motives and worries that their disclosures of abuse will be used against them (Sanderson, 2008). Roddy (2013) suggests that the client might take up to eight sessions to develop the feelings of safety necessary to disclose IPA experience. They note that the middle stage of treatment should involve a consideration and processing of any early childhood trauma, as well as adult traumatic experiences if necessary. The final phase is where the client begins to consider the possibility of terminating counselling, as they develop more self-confidence, reliance, and improved mental health. There are skills, knowledge and personal characteristics that are differentially important at various stages of the counselling process. A pictorial representation of the competency framework can be found in Figure 1.1 (Roddy & Gabriel, 2019).

Briefly, Roddy and Gabriel (2019) divide competencies in skills, knowledge, and counsellor characteristics. Skills involve areas such as boundaries and knowing when to seek out supervision. Knowledge involves awareness of ethics, counselling theories, and gender differences. Last, counselling characteristics involves attributes such as confidence, compassion, and being non-judgmental. The authors also note that there is overlap amongst these competencies. For example, skills and counsellor characteristics overlap to involve building trust, and being client led; skills and knowledge overlap to involve working with anxiety, picking up on indicators of abuse; counsellor characteristics and knowledge overlap to include knowing when to access personal support, and having high levels of self-care. Last, all three (skills, knowledge, and counsellor characteristics) overlap to include competency components such as advanced empathy, working with abuse disclosure, and working creatively. A complete description of these competencies and their relation to the individual phases can be found in Roddy and Gabriel (2019).

**Specific Therapeutic Techniques.** A number of specific therapeutic approaches can be used with men who experience IPA in counselling settings. These approaches are garnered from the literature surrounding the unique experiences of men who experience IPA. First, because men have been found to internalize the stigmatization surrounding their IPA experience (e.g.,

shame, discrediting), these self-perceptions often become impediments to clinical services (Gold, 2019). Adherence to this belief system (i.e., traditional masculine gender role beliefs), manifests in men's concealment of their experience of IPA, and can exacerbate the incidences of IPA and result in self-deprecation by the man. Thus, attention to this pre-existing personal schema is thought to be a necessary initial step in clinical intervention, as a basis for insight and eventual change (Gold, 2019). Further, cognitive counselling and narrative approaches have been suggested as appropriate methods for intervention, given the stigmatized nature of men's IPA experiences (Gold, 2019). Cognitive approaches should explore the client's beliefs about emotional abuse, his openness to viewing himself as a "victim," and what that "victim" status means to him (Gold, 2019, p. 511). Furthermore, for clients who desire a more collectivist perspective on abuse, this insight might be supplemented by integrating a narrative approach (Gold, 2019). This method can offer a societal view of gender role stereotypes as it pertains to IPA, and the ways that these expectations of there being a "correct" way of performing one's gender contribute to presenting psychological symptomatology (Gold, 2019). The clinician should also engage in psychoeducation surrounding characteristics of abuse, and about the pressures of traditional male gender roles, and how those can interfere with men accepting their experiences of IPA. Gold (2019) further notes that counsellors are faced with a paucity of best practices when working with men who experience IPA. Although several resources exist for providing therapeutic services to women who experience IPA, there is a dearth of those that are developed specifically for men (Gold, 2019). Gold suggests carefully weighing which interventions can and should be adopted and/or adapted for men and provides a suggested agenda for the process of therapeutic intervention with this population. Description of this agenda is beyond the scope of this dissertation (readers are referred to Gold, 2019, p. 512 for more information).

***Countertransference and Personal Bias.*** The therapist's personal reactions are also an important aspect of effective service provision with men who experience IPA. One descriptor for these reactions is that of countertransference. Countertransference can be defined as "internal and external reactions in which unresolved conflicts of the therapist, usually but not always unconscious, are implicated" (Hayes et al., 2018, p. 497). Countertransference can affect therapists as they may be influenced by a pre-conceived belief system, as well as societal stereotypes surrounding masculinity (Molloy, 2017). Counsellors also report that family of origin

can influence the therapeutic relationship (Brosi & Carolan, 2006). For example, by witnessing or experiencing abuse in one's upbringing, this might result in increased anxiety in the therapeutic space in response to hearing about violence (Brosi & Carolan, 2006). Conversely, some counselors note that a lack of these experiences in their family of origin makes it more difficult for them to understand or empathize with what their clients might be experiencing (Brosi & Carolan, 2006). It is thus important that the therapist reflects on these areas. Personal therapy and supervision have both been noted by counsellors as useful methods of attending to countertransference (Molloy, 2017). Conversely, in a study by Hogan and colleagues (2012) counsellors reported their male clients were afraid of being in the therapy room with a woman. Thus, counsellors must attend to both transference and counter-transference issues in the therapy room.

Personal bias is also a salient concern when working with clients, particularly those who are stigmatized, and who do not align with societal gender stereotypes. Researchers advocate for a change in the therapist's view of the female as the sole experiencer of IPA (Adams & Freeman, 2002). Specifically, counselling educators need to train counsellors to approach abuse with a gender-sensitive perspective, acknowledging that the incidence and impact are similar among genders, while the willingness to disclose differs greatly (Gold, 2019). Furthermore, current training emphasizes self-awareness regarding privilege and micro-aggressions within society (Gold, 2019). However, typically the individuals experiencing the abuse are members of marginalized or disenfranchised groups, where the perpetrators are the privileged groups in power (Gold, 2019). Thus, acknowledging the converse, where the privileged group is marginalized, and the disenfranchised group is now in power, can be a difficult cognitive adjustment (Gold, 2019). This issue necessitates acknowledgement of personal beliefs or biases, and how they might be exhibited in the therapy room (Gold, 2019).

### **Theoretical Bases of Service Providers' Attitude Development**

The overarching goal of the second study of my dissertation was to develop a theory regarding how counsellors develop attitudes and perspectives which are conducive to providing appropriate help to men who have experienced IPA. However, I did not review the literature regarding attitudes and service provisions until after my model had been developed. This was done in order to maintain the integrity of the model, and to ensure that I was not building the theory around my previous knowledge. This is in line with Charmaz's (2014) aforementioned



recommendations, where she suggests that one conduct an initial review of the literature prior to conducting one's research (as done above), in order to initiate inquiry and minimise presumptions, but to cease reviewing the literature during data collection and analysis. The following literature describes previous theoretical research surrounding service providers' journeys towards providing services, and my developed theory will be examined in the context of this research in the discussion section. Two topics in the literature presented as being particularly salient for comparison/contrast with the present dissertation results. Namely, the concepts of professional identity and professional development, and interacting/working with stigmatized populations. As such, the literature surrounding these two concepts will be reviewed below.

### ***Professional Identity Development***

Within the literature, many researchers have worked towards understanding the process of counsellor identity development. Professional identity has been defined in various ways in the literature (Alves & Gazzola, 2011). Despite these various perspectives, Alves and Gazzola (2011) note that "researchers generally agree that professional identity indicates one's work values, abilities, and knowledge; a sense of unity among the implicated professionals; and possessing personal responsibility to the profession, conducting oneself ethically and morally, and experiencing feelings of pride for the profession" (p. 190). Within this broad definition is the concept of individual professional identity, which is more pertinent to my study. Individual professional identity is defined as one's personal work values, knowledge, skills, personal growth, improvement and success at work, and innovation and imagination (Gazzola & Smith, 2007, as cited in Alves & Gazzola, 2011).

There is currently a dearth of research into the professional identity development of practicing counsellors (Luke & Goorich, 2010). Luke and Goodrich (2010) note that that which has been conducted focuses on later career counselors, counseling leaders, and counselor educators (e.g., Magnuson et al., 2003; Swickert, 1997, as cited in Luke & Goodrich, 2010). Further, to my knowledge there is no research specifically into the development of counsellors who work with certain and/or stigmatized populations. Rather, the vast majority of the identity research focuses on the transitions from student to independent clinicians. Overall, this research does not appear relevant to my research question. As such, only those studies which also mention

factors that might be important components of a counsellor's journey towards working with *stigmatized* populations will be reviewed here.

**Becoming Empowered.** Sawatzky et al. (1994) developed a cyclical model of counsellor development, specifically student development. The overall process is referred to as Becoming Empowered, and there are numerous stages within this process. The first stage involves experiencing dissonance, where students seek to advance their training, realizing that they do not know enough or have all the skills that they believe are desirable. This stage has two categories, namely recognizing gaps in skills, knowledge, and experience, and experiencing emotional turmoil (e.g., fear and embarrassment about not knowing things). The second stage involved responding to dissonance. This was done through acquiring new skills, information, and experience, changing attitudes, defining capabilities and limits, and withdrawing from further risk. The third phase was relating to supervision, whereby the student assesses the safeness of the supervisory climate, uses the supervisor and supervisory process as a model, responds to challenge and expectation, knows their limits, and becomes their own supervisor. The next stage involves feeling empowered, and involves changing perspectives, trusting self, clarifying and integrating personal and professional self, assessing other resources, and developing self-reflection. The final stage is where the student experiences increased competence (e.g., feeling satisfied with new skills, feeling a sense of autonomy, have a place as a professional, inviting collegiality, and learning as an ongoing process).

**Phase Model.** Rønnestad and Skovholt (2003) further developed a model describing the phases and central processes of counsellors' development. They posit six phases: "The Lay Helper phase, the Beginning Student phase, the Advanced Student phase, the Novice Professional phase, the Experienced Professional phase, and the Senior Professional phase" (p. 10). Within these phases, there are 14 themes of professional development, which present as particularly relevant to the present study: a) professional development involves an increasing higher order integration of the professional self and the personal self, b) the focus of functioning shifts dramatically over time, from internal to external to internal, c) continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience, d) an intense commitment to learn propels the developmental process, e) the cognitive map changes – beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise, f) professional development is a long, slow, continuous process that can also be erratic,

g) professional development is a life-long process, h) many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most, i) clients serve as a major source of influence and serve as primary teachers, j) personal life influences professional functioning and development throughout the professional life span, k) interpersonal sources of influence propel professional development more than ‘impersonal’ sources of influence, l) new members of the field view professional elders and graduate training with strong affective reactions, m) extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability, and n) for the practitioner there is a realignment from self as hero to client as hero (pp. 27-38).

### ***The Role of Personal and Professional Experiences***

The professional experiences that a counsellor has can play a significant role in the development of their professional identity. Doctoral students typically cite direct contact with clients as experiences foundational to their professional identities (Gazzola et al., 2011). Further, paradigm cases are typically noted as influential professional experiences. Benner (1985) states that a paradigm case is “a clinical episode that alters one’s way of understanding and perceiving future clinical situations. These cases stand out in the clinician’s mind; they are reference points in their current clinical practice” (p. 296). Paradigm cases may be good or bad, wanted or unwanted (Jensen, 2007). Some are straightforward and can be shared as stories that counsellors can integrate into their knowledge base and use to enhance their practice (Jensen, 2007). Thus, paradigm cases appear to be a particularly important component of counsellors’ development.

Research suggests that counsellors’ personal experiences can also play a significant role in how they interact with clients, and in the development of their professional identity (Alves & Gazzola, 2011; du Preez & Roos, 2008; Rønnestad & Skovholt, 2002). Nissen-Lie et al., (2015) notes that counsellors integrate their professional skills and education with their personal characteristics, to the extent that nearly blurs any distinction between them. Much has also been said of the concept of a wounded healer, which Zerubavel and Wright (2012) define as: “an archetype that suggests that a healer’s own wounds can carry curative power for clients” (p. 1). Relevant “wounds” found in the literature to be related to becoming a counsellor including belonging to marginalized groups (Henry et al., 1973), parentification (Bager-Charleson, 2010; DiCaccavo, 2002, 2006; Elliot & Guy, 1993; Farber et al., 2005; Racusin et al., 1981), and other personal experiences with hardships (Bugental, 1964; Hill, 2009).

### ***Working with Stigmatized Populations***

Bos et al., (2008) notes that the research on altering attitudes towards people who are stigmatized is typically organized into two groups: changing stereotypes about stigmatized peoples, and the pros and cons of contact with people who are stigmatized (Batson et al., 1997; Biernat & Dovidio, 2000, as cited in Bos et al., 2008). One of the most comprehensively researched theories surrounding personal contact with stigmatized populations is Contact Theory (Allport, 1954). Allport's (1954) conceptualization of intergroup contact theory posits that contact between groups under particular conditions can reduce prejudice (as cited in Pettigrew & Tropp, 2006). In particular Pettigrew and Tropp (2006), in reviewing Allport's work, noted that prejudice will be reduced when four specific features of the situation occur: equality between the two groups, common goals, cooperation, and societal support. Research further suggests that "four interrelated processes operate via contact and work to mediate attitude change: learning about the outgroup, changing behavior, generating affective ties, and ingroup reappraisal" (Pettigrew, 1998, p. 70).

This theory has received research support, with a meta-analysis conclusively demonstrating that intergroup contact reduces prejudice (Pettigrew & Tropp, 2006). This theory has also specifically been tested in professional groups, and research reviewed by Cabiati and Raineri (2016) depicts numerous recommendations for encouraging changes in professionals' stigmatizing attitudes, including increased training and education, and allowing for direct exposure to stigmatized people for trainees, namely exposure that highlights the stigmatized person's humanity and skills, as opposed to deficits or struggles (e.g., Scheyett & Kim, 2004; Shor & Sykes, 2002). In a similar vein, increased knowledge can act as a form of contact, whereby individuals are able to gain familiarity with the stigmatized population. Most germane to this research, mental health professionals with more professional experience (Lauber et al., 2006), training or education (Crawford et al. 1991), and higher levels of knowledge (Carney et al., 1994) have been found to hold more positive attitudes towards various stigmatized populations.

Changing stereotypes has been suggested as an additional method for reducing stigmatizing attitudes (Bos et al., 2008). When individuals are exposed to stigmatized group members who counter their stereotypes, stereotype change might occur, but only when the stereotype-disconfirming traits occur amongst most group members, and when disconfirming

traits do not differ drastically from the previously held stereotypes (Kunda & Oleson, 1995; 1997, as cited in Bos et al., 2008). Research depicts contradictory results of suppressing stereotype thoughts, with some results indicating that with high motivation and experience, people can effectively suppress stereotypes (Biernat & Dovidio, 2000). However, additional research suggests that stereotype suppression might have a counter-intentional affect. Specifically, stereotype suppression might actually result in a hyper-accessibility of the stereotype (Galinsky & Moskowitz, 2007), particularly amongst those with high levels of prejudice (Monteith et al., 1998).

### ***Summary***

As reviewed above, there have been multiple proposed theories and studies surrounding potential theoretical bases for professional development, identity, working with stigmatized individuals, and decisions to work with certain populations. Previous research indicates that attitudes towards and subsequent provisions of services to men who have experienced IPA are varied, and service providers and men alike report negative responses. Research further shows that personal experiences can play a significant role in counsellors' career choices and in their later professional development. Professional experiences further affect this professional development process. In addition to this, the two models of professional identity development models reviewed indicate that there are important components of professional identity development, such as experiences of dissonance, contextualizing your professional identity, and continuous self-reflection. Further, contact with stigmatized populations can serve as an effective method of reducing prejudicial attitudes towards them. Taken together, this research provides valuable insight into variables which might be influential during a counsellor's journey towards providing services to stigmatized populations. However, it is clear that there is a gap in the literature, specifically at the intersection between these bodies of literature. There has been no research directly into what motivates counsellors to work with specific populations, be it personal or professional experiences. The research is lacking regarding what aspects of a counsellors' journey are instrumental in determining the populations they choose, or are willing, to work with, and how they develop their conceptualizations and attitudes towards certain clients. Moreover, no research has been done into how and why certain counsellors want to work with and provide effective services to men who experience IPA, while others do not. Thus, my goal through this dissertation was to fill this gap in the literature and to utilize a grounded theory

methodology to develop a theory of the development of counsellors' identities as people who provide therapy to men who experience IPA.

## **CHAPTER 2: METHODOLOGY**

### **Overarching Theoretical Framework**

My dissertation project was guided by an overarching theoretical framework. Notably, through this dissertation I aimed to develop theories describing the processes guiding men's help-seeking journeys and counsellors' help-providing journeys. Thus, the theoretical framework described here is meant as a description of the theoretical underpinnings and guiding map for this entire dissertation project. As such, the theories developed and described in the results section are thought to operate within this broader theoretical paradigm and are discussed in the context of this system in the discussion section. Lysaght (2011) notes that: "a researcher's choice of framework is not arbitrary but reflects important personal beliefs and understandings about the nature of knowledge, how it exists (in the metaphysical sense) in relation to the observer, and the possible roles to be adopted, and tools to be employed consequently, by the researcher in his/her work" (p. 572). Sire (2004) further spoke of how theoretical frameworks are "worldview[s] of the heart rather than the mind" (p. 35). As such, I am adopting these understandings; the theoretical framework that I chose exemplifies my theoretical position regarding knowledge, individuals and their interactions with others, society, and the nature and goals of research. It further reflects a deeper, more personal perception of the way that the world operates, how we ought to treat one another as human beings, and our responsibilities to those around us as researchers.

#### **Identified Theories**

Multiple theories have been postulated to explain the occurrence of IPA. Traditionally, these theories have been put forth to understand women's experiences of IPA, and as such do not include consideration of gender. However, three predominant theories do attend to the concept of gender and acknowledge the occurrence of IPA against men: feminist theories, family conflict theory, and social learning theory. For the sake of brevity, theories of IPA that do not account for gender are not included. As will be elucidated below, I have chosen anti-oppressive feminist theories as a guiding lens for my dissertation, given their breadth and depth in applicability. However, both family conflict theory and social learning theory are briefly reviewed first.

#### ***Family Conflict Theory***

Family conflict theory (Bradbury et al., 2001; Steinmetz, 1986; Straus & Gelles, 1990; Straus & Gelles, 1988; Straus et al., 1980) posits that conflict is an inherent component of human

interactions, including family interactions. Conflict occurs because, despite the many shared interests between group members, partners, or couples, family members also have many different interests. Thus, conflict between family members (including intimate partners) is unavoidable, and violence is viewed as an option for resolving these expected disagreements (Lawson, 2012). At a basic level, this theory suggests IPA is caused by the commonplace building up or escalation of disagreements and stress that occur in the family (Lawson, 2012). According to this model, all partners contribute to violence in an intimate relationship, regardless of gender (Lawson, 2012). Johnson and Leone (2005) suggest family conflict theory is most appropriately used to explain more commonplace types of abuse, which occur reciprocally and are often limited in severity, amongst some couples (i.e., situational couple violence, explained above).

### ***Social Learning Theory***

Social learning theory, developed by Albert Bandura, posits that individuals learn social behaviours by observing, imitating, and modelling other people (Bandura, 1978; 1977; 1962). As applied to IPA, this theory:

Predicts that the prevalence of [IPA] is greater among those who have witnessed others they admire using aggression against a partner; who hold definitions that approve, only weakly disapprove, or are situationally neutralized with regard to the use of partner violence; who associate with significant others who hold definitions consistent with the use of partner violence and/or engage in partner violence themselves; and who anticipate a greater balance of social and non-social rewards from partner violence than costs. (Sellers et al., 2005, p. 383).

Two sub-theories within social-learning theory are typically used to explain IPA: the intergenerational transmission of violence theory (Curtis, 1963; Widom, 1989) and the background situational model (Riggs & O’Leary, 1989, 1996). The intergenerational transmission of violence theory asserts that “violence breeds violence” (Curtis, 1963, p. 386, as cited in Dardis et al., 2015), as well as that belief systems of violence can all be transmitted intergenerationally (Lewis & Fremouw, 2001, as cited in Dardis et al., 2015). However, not all children who are abused become violent in their later relationships, and thus the background situational model of violence was developed as a method to explain this discrepancy (Dardis et al., 2015).



The background situational model of violence posits that individuals have different levels of tendency to behave aggressively towards their partners (i.e., level of relationships aggressiveness; Riggs & O’Leary, 1996). Riggs and O’Leary (1996) suggest that aggressive behaviours towards partners depends on an individual’s level of relationship aggressiveness and the amount of relationship conflict. Furthermore, Riggs and O’Leary (1996) posit that early childhood experiences (e.g., observing violence), “sets the stage” for future aggression, through increasing people’s acceptance of violence and increasing their general aggressive behaviour (p. 523). Essentially, one’s acceptance of using violence in relationships and general level of aggression will increase how much conflict and arguing occurs in a relationship. Riggs and O’Leary (1996) further note that “these effects serve as the point of interaction between the background variables that relate to *who* will behave aggressively and the situational variables that identify *when* an individual will aggress against a partner” (p. 523).

However, according to Fox et al. (2016) social learning theory has been relatively silent on the issue of sex and gender. The few existing studies report mixed results, with some that Fox et al. (2016) reviewed showing that social learning factors are significantly more salient for men (Mears et al., 1998) and others finding social learning effects to be equally important robust between women and men (Alarid et al., 2000; Mihalic & Elliot, 1997). Mihalic and Elliot (1997) investigated this specifically in the context of marital violence and found that exposure to both experiencing childhood abuse and witnessing aggression between parents) led to a dramatic increase in the probability of marital aggression. Further, men and women who observed fathers hitting mothers were equally as likely to experience and perpetrate marital violence.

### ***Summary***

The two abovementioned theories provide us with a useful lens through which to understand the development and occurrence of abusive behaviours. However, they are limited in their scope. Namely, they exist to describe the occurrence of IPA, but do not serve as useful overarching models through which to view both the occurrence and the broader issue of stigma surrounding help-seeking and help-providing in this context. However, feminist theories fill this gap, and provide us with a useful lens to view the entirety of this societal issue. As such, I chose feminist anti-oppressive theory as my overarching theoretical framework.

### ***Feminist Anti-Oppressive Theory***

As will be reviewed below, feminist theories provide accounts for both men's experiences of IPA as well as for women's perpetration of IPA. However, given the scope of my dissertation, I will be focusing exclusively on feminist understandings of men's experience of abuse, as well as the intersection between feminisms and the difficulties associated with help-seeking and help-providing in the context of men's IPA.

**Feminisms.** Feminisms are longstanding theoretical approaches, which bring with them varied definitions and understandings (Kramarae & Treichler, 1985). Fawcett (1878) noted that the goal of feminism is to give women "the opportunity of becoming the best that her natural faculties make her capable of (p. 357). Rich (1979) stated that "feminism means finally that we renounce our obedience to the fathers and recognize that the world they have described is not the whole world...feminism implies that we recognize fully the inadequacy for us, the distortion, of male-created ideologies, and that we proceed to think, and act, out of that recognition" (p. 207). Mitchell and Oakley (1976) described feminism as "a method of analysis as well as a discovery of new material. It asks new questions as well as coming up with new answers. Its central concern is with the social distinction between men and women, with the fact of this distinction, with its meanings, and with its causes and consequences" (p. 14). hooks (1981) defined it as "a commitment to eradicating the ideology of domination that permeates Western culture on various levels – sex, race, and class, to name a few – and a commitment to reorganizing U.S. society, so that the self-development of people can take precedence over imperialism, economic expansion, and material desires" (p. 194-195). These definitions, among a plethora of others (Kramarae & Treichler, 1985) highlight the multifaceted and evolving nature of feminisms.

The evolution of feminisms is typically conceptualized as occurring in "waves." However, this metaphor of the waves of feminism has been critiqued as to its utility for current day use (Nicholson, 2015). Namely, Nicholson (2015) suggests that use of the term "wave" implies that "there is one phenomenon, feminism, that unites gender activism...and that like a wave, peaks at certain times and recedes at others...the wave metaphor suggests the idea that gender activism...has been for the most part unified around one set of ideas, and that set of ideas can be called feminism" (p. 1). As such, Nicholson suggests that a wave metaphor is problematic in its reductionism of gender activism. Further, Springer (2002) states that the wave metaphor "obscures the historical role of race in feminist organizing. If we consider the first wave as that

moment of organizing encompassing woman suffrage and the second wave as the women's liberation/women's rights activism of the late 1960s, we effectively disregard the race-based movements before them that served as precursors, or windows of political opportunity, for gender activism" (p. 1059).

Yet, the wave metaphor remains the longest standing and most well-known and utilized descriptor of the journey of gender-based theorizing and activism in the current literature, and thus will be utilized to describe the evolution of these theories and actions over time. However, we must recognize and critique its reductionist nature, and its erasure of Black feminisms and other race-based movements. Notably, numerous nuances and complexities are present within each "wave" of feminism. However, a thorough review is beyond the scope of my dissertation. As such, a brief review is provided below.

The first wave of feminism focused on "women's freedom and equality with men" (Swigonski & Raheim, 2011, p.11). Activists fought women's exclusion from public spaces and from history, and this first wave eventually resulted in women gaining the right to vote (Swigonski & Raheim, 2011). Typically, issues such as intersectionality (e.g., consideration of the experiences of women of color, socioeconomic status) were largely neglected (Swigonski & Raheim, 2011).

Second-wave feminism began in the 1960s (Swigonski & Raheim, 2011). This wave is marked by the idea of "women's liberation" (Swigonski & Raheim, 2011, p.12). Swignoski and Raheim (2011) noted that this wave was largely founded by women who "had the time and resources to put their stories, thoughts, and analyses into writing" (i.e., predominantly white women in academics; p.12). During this wave, the voices of women of color and individuals in the 2SLGBTQ+ community were often neglected, though these individuals remained active in theorizing and activism (Swignoski & Raheim, 2011). Calls for dialogue regarding various locations of difference and consideration of places of intersectionality were gradually becoming recognized (Swignoski & Raheim, 2011). Dominant concepts formulated and/or emphasized during this wave were concepts such as the patriarchy (i.e., men's exertion of power over women), reproduction (i.e., recognition of women's autonomy over their own bodies), and the personal as political (i.e., "challenging the separation between the public (male) sphere or work and the private (female) sphere of home and focusing attention of the politics and power differentials that are inherent in everyday life"; Swigonski & Raheim, 2011, p.12). An

overarching focus on gender was also inherent in this wave. Namely, theorists identified gender as being separate from biological sex, and discussed it as an “embodied and a constructed social reality” (Swigonski & Raheim, 2011, p.14). Swignoski and Raheim (2011) further note that analyses of care (i.e., as opposed to the “primacy of autonomy and independence as the pinnacle of human development” p. 16), power (individual, interpersonal, and institutional), difference (i.e., enabling women to “claim their identity as women as different from men on the basis of the unique qualities and characteristics of women as women, rather than as being which are not men”; p. 16), and diversity (i.e., race, age, class, sexuality, etc.), were central to this wave.

The third wave of feminism is said to have begun in the 1980s/1990s. A centering of inclusivity with regards to race, class, or sexual orientation was foundational to third wave feminisms (Swigonski & Raheim, 2011, p. 18). Essentially, the activists involved in this wave focused on inclusivity, intersectionality, and lived experiences, and they decried the concept of ‘perfectionism’ with regards to adherence to feminist principles. Swigonski & Raheim (2011) state that activists in this wave drew on the aforementioned calls of those in the second wave for attention to places of difference and strived towards celebrating and respecting diversities. Queer theory was also an incredibly influential component of this wave (Munro, 2013). Queer theory “posits that gender and sexuality are fluid categories, and do not easily map onto binary understandings of ‘male’ and ‘female’” (Munro, 2013, p. 23). Within this wave, theorists and activists worked to increased understanding and visibility of those in the 2SLGBTQ+ community (Munro, 2013). However, Munro (2013) notes that this process is ongoing, specifically as increased visibility of trans identities has occurred concurrently alongside increased discrimination against trans individuals, including from within feminisms.

As noted above, Black feminisms and other race-focused analyses are often disregarded in discussions of wave-based feminisms, and the concept of racism in particular has historically been ignored in white-feminisms. This was largely identified by bell hooks in her work “Ain't I a Woman” where she “noted the devaluation of black femininity, and the sidelining of women of colour within the feminist movement” (p. 23, as cited in Munro, 2013). However, Black feminists have emphasized examination of the interrelationships between race, gender, and class, that had historically been ignored by white feminists (Smith, 2013). Thus, Black feminists’ focus on various locations of intersectionality and works on antislavery, antilynching, anti-sexual

abuse, and suffrage (Springer, 2002), are integral to the entirety of feminist movements, and must be recognized as such.

As noted above, critics of feminist theories take issue with analyses focused exclusively on gender, and that ignore various locations of difference (Moosa-Mitha, 2005). However, Moosa-Mitha (2005) notes that although “mainstream feminism[s]” (p. 79) often fail to consider intersectionality, there are feminisms which are difference-focused. As noted above, third wave feminist theorists are working to recognize the imperative nature of divergent identities in their theorizing (Moosa-Mitha, 2005). These theorists are critical of mainstream theories, and understand freedom in “collectivist, relationship terms, [where] equality is interpreted as the right to be differently equal” (Moosa-Mitha, 2005, p.78). However, Moosa-Mitha (2005) notes that third-wave feminists are “still not the dominant version of feminism” (p. 78).

Decolonial feminisms have also been present throughout these waves, though have received increasing attention in the last decade. Coloniality is said to be dependence and/or continued enforcement of the norms, traditions, and systems that were created and imposed by the colonizers (Tlostanova et al., 2019). Decoloniality is then “an epistemic, political and cultural movement for emancipation from these limitations, foregrounding the fact that the achievements of modernity are inseparable from racism, hetero-patriarchy, economic exploitation, and discrimination of non-European knowledge systems” (Tlostanova et al., 2019, p. 290). As applied to feminisms, decoloniality is used to conceptualize women who have been oppressed through the intersectional “combined processes of racialization, colonization, capitalist exploitation, and heterosexualism” (p. 1). Tlostanova (2019) terms the “racialized, capitalist, gender oppression ‘the coloniality of gender’” and labels “the possibility of overcoming the coloniality of gender ‘decolonial feminism’” (p.1).

***Feminisms and IPA.*** IPA has been a longstanding focus of feminisms and the theories associated with feminisms. The traditional feminist theories of IPA focus on a patriarchal society that fosters a patriarchal family structure, where men are expected to have power over women (Bograd, 1988). At its core, this theory maintains that IPA results from “an underlying patriarchal system that encourages power and control struggles between women and men” (Dobash et al., 1992, as cited in Shorey et al., 2008, p. 289). IPA between intimate partners is thought to be a manifestation of already existing and enduring power structures of men’s dominance and women’s submissiveness, with power inequality believed to lead to violence and

abuse in relationships (Shorey et al., 2008). Because of this conceptualization, men are traditionally believed to offend, and women to experience IPA. Furthermore, when women are the aggressors, some feminist theorists primarily explain their violence as reactive and done in acts of self-defence and fear (Dobash et al., 1992; Saunders, 1988).

Acknowledging women's use of violence for feminists can be extremely, and understandably, difficult. Women's aggression, even in self-defence, has been used by perpetrators and society to blame those who experience IPA and to minimize the scope of violence against women (McPhail et al., 2007). However, although many feminist theorists have been hesitant to recognize men who experience IPA and women who perpetrate, some feminist researchers contend that an evolution of the feminist model is necessary; this model must address the fact that women can be perpetrators as well as experiencers of violence, and that "women can and do verbally, emotionally, sexually, and physically abuse [their] partners as well as their children" (McPhail et al., 2007, p. 828; e.g., McHugh et al., 2005; White & Kowalski, 1994; Young, 2014). Dim (2017), analyzing an article written by Young (2014) suggests that:

Women should be seen as fully human with agency, as ideally desired by liberal feminists, which includes the good sides and dark sides of their humanity; all sides should be brought to the fore. In other words, if we claim that women deserve leadership positions with male-dominant privileges and rights, then we can also accept that women can commit the atrocities and brutal behavioural tendencies displayed by men, including IP[A]. (Dim, 2017, p. 9)

McHugh and colleagues (2005) contend that refusal to recognize and investigate women's use of violence can undermine the feminist agenda of addressing men's violence against women and can result in individuals with other ideological and etiological perspectives being the only ones to address the issue. As such, some feminist theorists emphasize that there are a variety of reasons why women use violence. As noted above, there is a plethora of feminist research into women's use of violence and abuse tactics against her partner (e.g., DeKeserdy, 2011; McHugh et al., 2005). However, given the scope of this dissertation these will not be further reviewed here.

***Feminisms and Masculinity Scholarship.*** Dowd (2010) noted that masculinities scholarship is essential to feminist analyses: "it requires that we 'ask the man question' to further

unravel inequalities” (p. 415). Dowd (2010) further posits that we have a tendency to argue over whose issues are most significant, but it is imperative that we resist this “either/or” approach or “hierarchy of inequalities” (p. 417). Dowd (2010) argues that feminist theories have continued to evolve, through questioning, disputing, and debating itself, and that incorporating the study of men and masculinities continues that tradition, and attempts to correct an “essentialist, limited view of men” (p. 418). This method of analysis can allow us to understand how the current cultural conception and structure of gender harms and oppresses boys and men as well.

However, theorists now describe this oppression of men as a part of the anti-feminist rhetoric. These theorists deny that women are oppressed, and even view women, particularly those who identify as feminists, as oppressors of men (e.g., Farrell, 1993, as cited in New, 2001). However, New (2001) argues that both men and women are both oppressed, though in different ways. New (2001) suggest that men are positioned to act as the primary and systemic agents of oppression against women, while women are not in the position of subsequently oppressing men. Yet due to the ostensible relational nature of gender, “the two oppressions are complementary in their functioning – the practices of each contribute to the reproduction of the other” (New, 2001, p. 730). New (2001) specifically argues sex roles and traditional masculinity narratives operate to oppress men. Thus, although men frequently oppress women, and often benefit from this, they too experience oppression as a result of this gender order. New (2001) further draws attention to a quote by Segal (1997) to elucidate this concept: “Men were... conditioned into competitive, inexpressive, restrictive masculine roles which were both physically and psychically damaging, inhibiting expression of their authentic selves” (p. 68).

This conceptualization of the oppressive nature of gender expectations, and a belief in anti-essentialism is central to feminism (Crenshaw, 1989; Dowd & Jacobs, 2003; Harris, 1990). According to Witt (1995), essentialism “refers to the thesis that certain of an object’s properties are necessary to it” (p. 321). With this in mind, the thesis of gender essentialism posits that there are properties necessary to “be” a gender, such as the necessity to be nurturing, or be oppressed, or have a uterus, in order to be a woman (Witt, 1995). Anti-essentialist feminists “reject the thesis of gender essentialism [ - ] they deny that there are any properties that [one has] necessarily insofar as [they are a particular gender]. Or, to use the variant, they reject the existence of a generic [gender]; there is no single, shared property or properties that must be satisfied in order to count as [the gender one identifies with]” (Witt, 1995, pg. 322).

This idea of essentialist masculinity can be further explained through the concept of “the hegemony of men” (Hearn, 2004, p. 59). Surman (1994) states: “hegemony is taking one way of seeing things, and convincing people that this way of seeing things is natural, that it is ‘just the way things are’” (as cited in Hearn, 2004, p. 61). The main goal of investigating this hegemony of men “concerns the examination of that which sets the agenda for different ways of being men in relation to women, children and other men” (Hearn, 2004, p. 59). Basically, through what ways are men told to be men, and what do these messages entail?

This dominant conceptualization and script of masculinity at present is often referred to by theorists as hegemonic masculinity (Connell, 1997). Hegemonic masculinity highlights the dominant position of men within Western cultures, and the theory behind it posits that there are multiple versions of performed masculinity, and these versions exist along a dynamic continuum of power (Connell, 1997). It is thought to be:

a set of values, established by men in power that functions to include and exclude, and to organize society in gender unequal ways. It combines several features: a hierarchy of masculinities, differential access among men to power (over women and other men), and the interplay between men’s identity, men’s ideals, interactions, power, and patriarchy. (Jewkes & Morrell 2012, p. 40).

Hegemonic masculinity is typically associated with characteristics of un-emotionality, independence, lack of nurture, aggression, and being dispassionate (Collier, 1998), and begets expectations of taking charge and denying need for assistance, as this is a sign of weakness (Collier, 1998). Although it is thought to be the “culturally exalted form of masculinity...[it] might only correspond to the actual characters of a small number of men” (Carrigan et al., 1985, p. 592), yet remains a theorized vantage point to which other performances of masculinity are compared (Connell & Messerschmidt, 2005).

In sum, feminist theories suggest that relying on essentialist conceptualizations of gender results in prejudice and discrimination when an individual does not adhere to what is expected from their gender. This prejudice can be both internal (i.e., self-imposed), and external (i.e., imposed by society). Feminist theories suggests that men are hesitant to seek help because victimization, and particularly victimization at the hands of a female, does not align with hegemonic conceptualizations of masculinity. Further, this theory accounts for counsellors’ and other service providers’ negative reactions. Encountering a man who has experienced IPA might



go against a helping professionals' internalized understandings of how a man should behave, based on the hegemonic script of masculinity. Thus, they are inclined to either not believe them or react in a way that punishes this gender-role transgression (e.g., mocking the man).

**Anti-Oppressive Theories.** Baines (2007) describes anti-oppressive theories in this way: Rather, than a single approach, AOP [anti-oppressive practice] is an umbrella term for a number of social justice oriented approaches to social work, including, feminist, Marxist, post-modernist, Indigenous, post-structuralist, critical constructionist, anti-colonial and anti-racist...As part of larger movements for social change, AOP is constantly refining its theory and practice to address new tensions and social problems, as well as underlying structural factors (p. 4).

Broadly speaking, according to AOP, injustices based on gender are theorized through this model as “occurring as a result of patriarchal conventions and assumptions that exist at ideological, institutional, and societal levels” (Dominelli, 2002, p. 76, as cited in Moosa-Mitha, 2005, p. 76). Anti-oppressive theories attend to locations of difference as well as emphasizes the imperative nature of social justice (Moosa-Mitha, 2005). Approaches which are difference-centered defy societies' postulations of what is normative, and instead highlight how diverse and complex reality and knowledge truly are (Moosa-Mitha, 2005). In this way, anti-oppressive theorists speak of the imperative nature of recognizing intersectionality. As noted previously, intersectionality is “a dynamic concept that seeks to uncover oppression as it exists within, between, and in relation to social identity categories in their multiple interactions with the changing structural, political, and cultural levels of society” (Moosa-Mitha, 2005, p. 86). Moosa-Mitha (2005) further speaks of these theories as attending to the fluid and changing nature of social identities. The dynamic nature of this position acknowledges that people can hold multiples relationships, where an individual can “be both oppressed and oppressor at the same time” (Razack, 1999, as cited in Moosa-Mitha, 2005, p. 86).

These theories beget both ontological and epistemological assumptions, which align with my own personal assumptions (described below). Ontologically, post-modern theories acknowledge that oppression is both an idiographic, as well as a collective experience (Moosa-Mitha, 2005). Furthermore, research participants are active agents in the research process, and their agency is highly valued (Dominelli, 2002, as cited in Moosa-Mitha, 2005), with the participant being centered as the expert (Moosa-Mitha, 2005). Furthermore, the emphasis of the

research analysis is on: “enabling free expression of differences in self-identity and identifying resistance outside of prescribed expectations” (Moosa-Mitha, 2005, p. 88). As such, researchers should not begin the research with previously developed hypotheses, but rather should allow for the unique and personal nature of participants’ stories to be shared freely (Moosa-Mitha, 2005).

Epistemologically, anti-oppressive theories emphasize multiple ways of knowing (Moosa-Mitha, 2005). Moosa-Mitha (2005) notes that knowledge is thought to be subjective, founded in lived experiences, “situated and subjugated,” and partial (i.e., not everything can be known; Moosa-Mitha, 2005, p. 88). The development of knowledge is understood to be a dynamic, reciprocal process, engendered through interactions between individuals, with both parties being integral and agentic in defining the knowledge (Hall, 1996, as cited in Moosa-Mitha, 2005). Within this, the researcher is positioned as a learner, where they are making efforts to understand what the participant knows through being critically self-conscious and empathic (Moosa-Mitha, 2005). This process necessitates reflexivity on the part of the researcher, whereby they must “reflect on the dominant practices in which [they might be] complicit (Lather, 1991, as cited in Moosa-Mitha, 2005, p. 89).

Last, anti-oppressive research projects have a liberatory intent, whereby they emphasize action as subsequent and integral to knowledge gathering (Moosa-Mitha, 2005). Research conducted within this paradigm is developed with an intention to elicit change, and to elicit change that is identified by participants as important and meaningful (Moosa-Mitha, 2005).

**Intersection with the Current Research Project.** The current dissertation project drew from the various principles, concepts, and tenants of the aforementioned theoretical framework. Feminist Anti-Oppressive theories emphasize the importance of addressing instances of inequality and oppression in our world. The issue of men’s experiences of female-perpetrated partner abuse is an instance of injustice and deleterious trauma that is occurring in our world today. Not only is it a significant issue on its own, but as a theorized result of a patriarchal, essentialist vision of masculinity, men experience personal and societal obstacles to seeking and receiving help for this abuse. Conversely, counsellors are met with challenges, both personal and professional, in providing services to this population. This is a phenomenon that requires action to be taken to evoke change – men’s experiences of abuse are real and severe and should be acknowledged as such. Subsequently, the severity of these experiences necessitates that help be available and accessible, which research suggests it is not. My dissertation research questions

and goals were thus directed by anti-oppressive feminist theories. I wanted to address the patriarchal restraints placed upon femininity and masculinity in the context of IPA, and encourage the full expression of both, within all sexes and genders. The very nature of this issue engenders the utilization of an anti-oppressive framework, with an emphasis on the influence that intersections of gender and power have on men and counsellors' experiences.

I paid close attention to intersectionality throughout the research process. Social positions of gender, age, physical ability, culture, sexuality, and ethnicity have an indelible influence on individuals' experiences of partner abuse. Moreover, through this process I recognized individuals' unique, diverse, and multiple social locations, where one an individual can both be oppressed and oppressor at the same time (Fellows & Razack, 1998). This has an important intersection with feminist theories, whereby the patriarchy works to uphold men's power and privilege, while concurrently limiting and oppressing these same men. Similarly, these social positions can play an important role in one's journey towards providing help to different populations. My application of feminist anti-oppressive theory encompasses an approach aimed at social justice, emphasizes the locations that individuals experience the world from, and focuses on the influence of gender on these experiences. I believe that focusing exclusively on gender as the lens to theorize through (as with some feminist theories), is a limited, privileged approach, that does not pay homage to the multifaceted nature of oppression. Thus, I believe that the intersection between these two theories appropriately attends to the complex nature of the phenomenon under study.

In alignment with the ontological and epistemological assumptions of this theory, I employed a qualitative approach to this research project. Specifically, a grounded theory approach allowed for individuals to be centered as experts, and for them to tell their own stories. Additionally, this approach allowed for the reciprocal and dynamic nature of knowledge gathering and development to be honored, as I could develop relationships with participants, hear their stories, and ask my own questions in order to cultivate my own personal understanding of their experience. In alignment with anti-oppressive theories, codes, categories, and hypotheses were not developed a-priori. Although I had a degree of theoretical sensitivity entering into the analyses (i.e., ideas regarding what concepts might be important), I made all efforts to not fix these ideas on to the data, and to allow codes and categories to arise from the participants' own words. However, with using a feminist anti-oppressive theory as guidance, I also paid close

attention to the influence of social identities, power, and oppression on individuals' stories, and will comment on these in the discussion section.

Within this, this process involved a significant amount of reflexivity. At the end of this document, I highlight a number of ways in which my personal self is integrated within this project. Throughout the research process I also engaged in memoing about my thoughts and feelings, and these memos helped me to develop the categories and theory, as well as to narrow in on content for the discussion section that I believed to be important. This process was incredibly reciprocal, where I asked questions of participants, they shared their knowledge, I interpreted that knowledge, and their stories influenced further questions of future participants. With this, the results are both an interpretation of the idiographic nature of participants' stories (i.e., close attention was paid to each individual story, codes were assigned, and important concepts were highlighted as discussion points), as well as a recognition of the collection nature of oppression that participants experience (i.e., the development of a comprehensive theory, that is a conglomerate of all participants' experiences).

Last, a feminist anti-oppressive theory necessitates that my research project be developed with the intention of eliciting action and change in society. We do research in order to incite discussion, action, and revolution regarding systems of oppression. As such, we must conduct research on those topics in a way that lends itself to these sought-after outcomes. My research is aimed at changing those systems and processes which limit men's willingness and ability to seek and receive professional help. The reason that I chose to develop theories, is because I truly believe in hooks' (1991) postulation that theory and practice inform each other; if something can be understood through a theoretical lens, then action can be taken against it. Theory provides us with a roadmap through which we can understand phenomenon. With this, it provides us with an understanding of different entry and exit points along individual's journeys. It is through an understanding of these points that we are able to effectively intervene. A thorough description of the translation of this theoretical understanding into practical recommendations for change can be found in the discussion section.

### **Overview of Study Objectives**

The main purpose of my dissertation was to understand the processes behind seeking, receiving, and providing help for IPA. That is, through my dissertation I aimed to understand the

process<sup>7</sup> that men go through to seek help for IPA. I also aimed to provide insight into the other side of help-seeking experiences. Specifically, I wanted to understand how counsellors “become” someone who provides help to men who experience IPA. This is a particularly novel approach, given the limited amount of qualitative research into service providers’ perceptions of men who experience IPA and the complete lack of a grounded theory developed to understand these perceptions, as well as this process of seeking help. Using a bottom-up approach, this knowledge was co-constructed with men who experience IPA, who themselves engage in the decision to seek or not seek help, as well as with counsellors, who concurrently can often decide what help (if any) to provide. These two models were developed simultaneously, providing a unique opportunity for myself as a researcher to reflect upon how these models might intersect for these two groups (i.e., men who experience IPA and counsellors).

The objective of Study 1 was to construct a grounded theory delineating the process of seeking and receiving help for IPA, namely the process that men who experience IPA go through when deciding to use helping services. Based on previous research, I expected that certain constructs of masculinity, gender roles, previous help-seeking experiences, trusting relationships with informal supports, typologies, as well as severity of IPA might possibly emerge as part of the model of help-seeking behaviours and experiences. However, given the inductive nature of grounded theory, I did not make any specific *a priori* hypotheses about the involvement of these variables in the final model. Moreover, I employed specific grounded theory techniques designed to minimize the impact of previous knowledge including reflexivity, memoing, and theoretical sampling.

The objective of Study 2 was to build a complementary theory delineating the process of providing therapeutic services to men who experience IPA, namely the process of how counsellors become someone who provides help to men who experience IPA. I expected that that amount of experience and training, personal experiences with people who experience IPA, and traditional gender beliefs might emerge as parts of the model of service provision to men who experience IPA. However, as in Study 1, I did not make specific hypotheses due to the inductive nature of grounded theory, and I utilized the same components designed to maximize awareness of the process of reaching conclusions in grounded theory. I also hypothesized that the theory

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<sup>7</sup> The terms “model” and “process” will be used interchangeable throughout this document to refer to my results depicting the journeys of help-seeking and help-providing.

derived from Study 1 would inform many of the questions asked of the counsellors in Study 2, and vice versa

## **Data Analysis Strategy**

### **Telephone Interviews**

For both Study 1 and Study 2, I conducted interviews with participants over the telephone. There are differing opinions in the literature regarding whether telephone interviews or in-person interviews are most appropriate in research. Specifically, qualitative methodological texts have traditionally advised that conducting interviews over the telephone is not appropriate for qualitative research (McCoyd & Kerson, 2006; Rubin & Rubin, 1995). The most typically cited concerns regarding telephone interviews include difficulties establishing rapport (Shuy, 2003), lack of non-verbal information (Mealer & Jones, 2014; Tausig & Freeman, 1988), and potential loss of contextual data (e.g., appearance; Opdenakker, 2006).

However, there have been a number of counter arguments presented, suggesting that these limitations of telephones interviews might not be as detrimental to the research process as originally thought. For example, with loss of nonverbal information, research suggests that there are several methods that we can use to compensate. For example, by listening carefully, the interviewer can attend to and identify affect without visual cues (Tausig & Freeman, 1988). Tausig and Freeman (1988) emphasize the importance of “rel[ying] heavily on such discernible auditory cues as verbal tension or anger, manifested by sarcasm, curt responses, slowed speech, difficult articulation, sadness, tears, or rapid, compulsive speech that often indicates anxiety” (p. 424). Interviewers can then integrate that information within the interview transcript. As such, throughout the transcripts, myself and my research assistants noted when participants laughed, cried, or exhibited other emotional states. Dicker and Gilbert (1988) also note that feedback and/or reassurance for telephone participants must be communicated through “paralinguistic utterances” (e.g., mhms, yes, ahh) to compensate for the unavailability of non-verbal forms (e.g., head nods; as cited in Irvine et al., 2013, p. 91). This can help to encourage participants to continue sharing their stories, as well as communicates continued attention, concern, and interest (Chapple, 1999; Miller, 1995), and was this approach was employed throughout the interviews.

With regards to rapport building and interview comfortability, we should recognize that in many cultures today, people are well-versed in telephone communication both informally and in more formal settings such as counselling or specialist hotlines (Irvine et al., 2013). Further, a

plethora of researchers have reported that they successfully established rapport with their telephone participants (e.g., McCoyd & Kerson, 2006; Stephens, 2007). Notably, all of my participants presented as forthcoming, and rapport appeared to develop easily. Further, all participants in both studies agreed to be contacted for a follow-up interview. Further, when provided the choice between a telephone interview or an in-person interview (as recommended by my Indigenous advisory committee), the one participant who was presented with this decision chose a telephone interview.

In addition, research also suggests that the use of telephone interviews presents unique advantages over face-to-face interviews. Opdenakker (2006) notes that telephone interviews can be particularly advantageous for increasing geographic range and interviewing difficult-to-reach populations (e.g., new mothers, individuals in war zones). Others note decreased cost of travel (Aday, 1996) and anonymity reducing feelings of self-consciousness (Hyman, 1954). Furthermore, Mealer and Jones (2014) state that telephone interviews might be preferable for interviews regarding sensitive or traumatic topics (e.g., IPA). Some researchers also suggest that telephone interviews might mediate power dynamics that can be present in the researcher-participant relationship (Drabble et al., 2016), which is notable given the salience of power dynamics for individuals who have experienced trauma. Furthermore, the sense of anonymity allotted with telephone interviews (Hyman, 1954) might be a particularly salient advantage for my participants, given the stigmatized nature of the topic, and previous research outlining the difficulty that many men have in reporting and discussing their experiences of abuse.

In sum, researcher's perceptions in the literature appear to be moving towards both accepting and even advocating for the use of telephone interviews in qualitative research. It appears that by attending to the participant fully, and incorporating vocalizations and clarifying questions, that data-loss can be prevented, and rich information can be gathered. Additionally, telephone interviews appear to be advantageous over face-to-face interviews, as they present as trauma-informed, sensitive, and comfortable ways for participants to share their stories.

### **Grounded Theory Methodology**

Grounded theory was originally developed by Glaser and Strauss (1967) and has since been altered and adapted by several different researchers. One of the most recent adaptations of this method is known as constructivist grounded theory (e.g., Bryant, 2002; Charmaz, 2014, 2013, 2008, 2006, 2000; Clarke, 2005, 2006; Mills et al., 2006a; 2006b; 2006c), and this is the

type of analysis that I utilized for this proposed study. Constructivist grounded theory is a form of grounded theory that incorporates the epistemological position of social constructivism (expanded upon below). This method is also conceptualized as an emergent method: “the method does not stand outside the research process; it resides within it” (Charmaz, 2013, p. 160). This method focuses on developing a theory that is ‘grounded’ in the data but does so in relation to the conditions of the research and the standpoints and interactions of the researchers (Charmaz, 2008, 2014). It contends that, despite the researchers being aware of what they contribute to the study, they are viable parts of both the research process and product; the research is a product of the time and socio-cultural context in which it is performed (Charmaz, 1995). Thus, researchers who utilize this method view themselves as embedded in the research process, as opposed to objective, distanced observers of the phenomenon that they are studying (Charmaz, 1995). Further, the grounded theory approach employs inductive data collection and data analysis, an iterative process of oscillating between data and analysis, comparisons, and encourages a consistent interaction and involvement with the data and analyses (Charmaz, 2006, 2014).

A number of integral facets to grounded theory must be attended to throughout the research collection and data analysis processes. One of the most important first steps in conducting a grounded theory analysis is recognizing the iterative nature of the process, such that the researcher will vacillate between collecting and analyzing data. This process is known as *theoretical sampling* (Charmaz, 1996)

The initial data are coded as they are collected, which means applying a succinct label to a piece of data to define what it means. *Codes* are means to synthesize, synthesize, and sort the data, as well as to fragment the data, define processes in the data, and to make comparisons between data (Charmaz, 1995). Grounded theorists have identified multiple different types of coding. For the present study, I utilized open and focused coding (Charmaz, 1989). *Open coding* is the initial line-by-line or word-by-word examination of the data, with a focus on developing provisional concepts (Glaser, 2016). Via constant comparison, these concepts are then collapsed into categories (Glaser, 2016). In *focused coding*, the analysis is specifically focused on an emerging category (Thornberg & Charmaz, 2014). Focused coding refers to taking commonly appearing initial codes, and then using those codes to organize large amounts of data (Thornberg & Charmaz, 2014). Thus, focused coding is less open-ended and more directed than initial coding (Thornberg & Charmaz, 2014). This coding allows the researcher to sort and synthesize



large amounts of data (Thornberg & Charmaz, 2014). Grounded theorists examine their focused codes to determine which ones best explain or interpret the empirical phenomenon (Thornberg & Charmaz, 2014). These codes then become tentative theoretical categories (Thornberg & Charmaz, 2014).

Another important facet of grounded theory analysis is utilizing a *constant comparative analysis* (Birk & Mills, 2015). This method involves continually interacting with the data, comparing data with other data as you code, and checking emerging theoretical categories when collecting additional data to determine if such categories are appropriate. Constant comparison occurs both within-persons (i.e., comparing one participant's statements about a phenomenon to their other statements) and between-persons (i.e., comparing participants' statements to one another; Birk & Mills, 2015). For example, one might analyze data first on the level of an individual interview, and then compare those data across other subjects to identify similar and/or divergent categories (Birk & Mills, 2015).

Incorporated into all stages is the process of *memo writing*. This process involves the researcher keeping a written record of their thoughts throughout the research process, including "ideas and reflections about the broad research process, as well as potential explanations and definitions for codes and theoretical categories" (Charmaz, 2014, p. 174). Memo writing should begin at the conception of your research, and can be utilized to explore ideas about categories, making comparisons between categories, and build your analysis (Charmaz, 1995). These memos assist the researcher in describing, conceptualizing, and forming their final theoretical categories and emerging theory (Charmaz, 1995).

The data collection and analytic processes end once the researcher has reached *theoretical saturation*. This is "the point in category development at which no new properties, dimensions, or relationships emerge" (Strauss & Corbin, 1998, p. 143). In the literature, there is a diversity of perspectives regarding saturation. For some, saturation means "data adequacy," and is defined as "collecting data until no new information is obtained (Morse, 1995, p. 147). Mead suggested that one index of saturation is the boredom that occurs when investigators have heard it all (as cited in Morse, 1995). A slightly more complex position is taken by Glaser and Strauss (1967), where: "saturation means that no additional data are being found whereby the sociologist can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated" (p. 61).

Additional review of the various definitions and approaches to theoretical saturation can be found in Saunders et al. (2018).

According to Morse (1995, p. 149), there are some important principles of saturation to attend to, when determining whether/when your study has reached saturation. 1) Cohesive samples, and narrow research questions, will result in faster saturation, 2) Saturation is achieved sooner if you utilize theoretical sampling, 3) Utilizing negative cases will assist in streamlining saturation, 4) Saturated data is complete and holds depth, and the theory is comprehensible and without gaps, and 5) The more thorough the saturation, the more comprehensive, and understandable the theoretical model will be. These considerations are discussed as indicators of theoretical saturation in the results section.

Thus, theoretical saturation in the present grounded theory studies is defined by a conglomerate of these aforementioned perspectives. Based on Saunders et al. (2018), theoretical saturation for this project was deemed to be reached when there was no new data arising from participants' stories, when there was no new data that is not accounted for by categories, when the theory was fully supported by the data, when I felt that I had a full understanding of participants' perspectives on the phenomenon, and in consultation with my research advisor. Further, theoretical saturation involved saturation at both levels of data (i.e., redundancy in data), and theory (i.e., completeness of theory and categories, and the presence of participants' voices within each theoretical category).

A final consideration within grounded theory analysis is regarding how or if the researcher should engage with the literature, and current opinions on this topic are dissenting. Traditional grounded theorists suggest that "an effective strategy is, at first, literally to ignore the literature on theory and fact in the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas" (Glaser & Strauss, 1967, p. 37). However, Strauss and Corbin (1998) identify many positives for engaging proactively with the literature, such as being able to weave the literature throughout the process of the evolving grounded theory and adding an additional voice to the researcher's theory construction. One predominant critique of ignoring existing theory, is the risk it poses for "reinventing the wheel" (Goldkuhl & Cronholm, 2010, p. 191). Goldkuhl and Cronholm (2010) argue that developing a theory in isolation from pre-existing literature risks "noncumulative theory development" (p.191). Rather, they recommend that existing theory be used as

foundations for new theories (Goldkuhl & Cronhold, 2010). Moreover, in practical regards it is difficult to avoid all literature during the research process. For example, as part of my dissertation I was required to defend a dissertation proposal, which would have been impossible without reviewing any literature.

As noted above, I followed Charmaz's (2014) recommendations. She suggests that one conducts an initial review of the literature review prior to conducting one's research (as done above and in my dissertation proposal), in order to initiate inquiry and minimise presumptions, but to cease reviewing the literature during data collection and analysis. Once the grounded theory has been developed, Charmaz then recommends revisiting the literature to uncover, assess and defend the emergent theory (Charmaz, 2014). Despite awareness that there are established theories of help-seeking and help-providing, having a theory which is grounded in the participants' lived experiences, and contextualized within the area of men who have experienced abuse, is an imperative addition to the literature. It is only with this specificity that we will be able to understand the nuances of this phenomenon and elicit meaningful change in men's help-seeking journeys. As such, I reviewed much of the literature surrounding my dissertation topic during the development of my dissertation proposal but did not review in depth the pertinent *theoretical* literature surrounding help-seeking and help-providing. Thus, I had expectations that certain constructs would emerge within my data, but I intended to create my grounded theory inductively rather than deciding *a priori* to search for these constructs. A more reflective description of this decision to engage and/or not engage with previous literature can be found in the reflexivity section

The end goal of grounded theory is to develop a theory that is grounded in the data (Charmaz, 2006, 2014). This method favors theoretically analyzing significant processes in the data rather than the participants' narratives as a whole (Birks & Mills, 2015), and aims to develop context-based theories by way of identifying and integrating categories of meaning that are constructed and emerge from the data (Willig, 2008). The resultant theory provides researchers with an explanatory framework, and it is this explanatory ability that differentiates grounded theory from most other qualitative approaches (Birks & Mills, 2015; Willig, 2008). Furthermore, part of the explanatory power of grounded theory is its predictive ability – grounded theories can help to explain what might happen to, for instance, another man who has

experienced abuse, or a counsellor who has just heard that IPA can happen to men, in a related context (Douglas, 2003).

As such, this method was utilized to construct a theory regarding the process of men's help-seeking, and of counsellors' help-providing—a theory that will ideally hold explanatory power for these two phenomena. A visual depiction of the grounded theory process can be found in Figure 2.1 (Lowe, 1995; Pigeon & Henwood, 1996; Dey, 1999, adapted by Gasson, 2004).

### ***Grounded Theory and Study 1 & 2***

I chose grounded theory analysis for both Study 1 and Study 2 because I wished to develop a “broad, more abstracted understanding” of the phenomenon of help-seeking, help-receiving, and help-providing, in the context of men's experience of IPA (i.e., to develop a theory; Haverkamp & Young, 2007, pg. 273). Lincoln and McGorry (1995) note that a first step in developing a model of help-seeking is to speak directly to those who seek and provide help. It is for these reasons that qualitative inquiry utilizing grounded theory analysis was determined to be the most appropriate method for this dissertation. The aim of this research study, aligned with my methodology, was to produce a theory constructed from, and grounded within, the data itself to better understand men's decisions to seek help, and the process through which they seek and receive that help, as well as the process of counsellors' perceptions of and responses to men who experience IPA.

Although considerable research has investigated men's experiences of abuse and of seeking help, the underlying *process* of help-seeking and -receiving has not been studied. That is, no explanatory, theoretical model exists for the process underlying this experience. At present, we do not understand how men come to realize that they need help, how they seek that help, if/how they persist despite negative help-experiences, and how this process might lead to eventual healing from abuse. Developing a theory for this experience provides a model identifying men who complete the process (e.g., seek help, receive help, and recover from the abuse) and those who exit the process at different stages (e.g., experience unhelpful services and remain in the abusive relationship). This can provide service providers with important information regarding how best to ensure men stay on the path to recovery, and how best to intervene.

Furthermore, although previous research shows that men experience negative reactions from service providers, and that some counsellors hold certain biases and prejudices against men

who experience IPA, the process of how counsellors come to develop their conceptualizations of men who experience IPA, specifically those who currently work with this population has not been studied. We currently do not fully understand why some counsellors hold negative perceptions towards and respond negatively to men who experience IPA, while others accept their experiences and are willing to provide services, nor how they navigate influential societal biases when they are required to provide services, and how some eventually come to provide effective and bias-free services. Developing a theory for this experience will provide a model identifying counsellors who complete the process (e.g., “become” someone who is willing to provide help to men who experience IPA) and those who exit the process at different stages (e.g., decide that this issue is not serious enough to warrant provisions of help). An understanding of this process can help in developing and implementing training programs for counsellors who might work with this population.

### **Epistemological and Ontological Positions**

Central to performing qualitative research is identifying and defining one’s epistemological and ontological positions. These positions will influence the entire research process, from the choice of research topic to one’s final interpretation of the data. Epistemology consists of the question of “how we know what we know” (Crotty, 1998, p. 8). Charmaz (1989) posits that “grounded theory research analyses can be enriched by clarifying the researcher’s epistemological premises” (p. 1171). As such, my dissertation research will be grounded in a social constructionist epistemology. This means that I adopted the view that truth and meaning, and by extension my research data, were constructed through interactions with the world and the individuals within it (Crotty, 1998). Further, these meanings may be constructed in entirely different ways by different people, even in response to the same phenomenon (Crotty, 1998). Burr (2015) notes four key assumptions of social constructionism. First, it takes a critical stance toward taken-for-granted knowledge and asks us to question the idea that knowledge is based upon objective observations. Second, it assumes that knowledge is specific and dependent upon context (e.g., history and culture). Third, social constructionism assumes that knowledge is constructed through individuals’ interactions with each other. Last, this epistemological position holds that these constructions of the world maintain some patterns of social action whilst excluding others.

Ontology is the “study of being,” and specifically concerns itself with what truly constitutes reality (Crotty, 1998, p. 10). My ontological stance is that of relativism. A relativist position asserts that an objective truth does not exist, but knowledge is created through shared experiences and relationships with people (Charmaz, 2006). Under this ontological perspective, a completed grounded theory is a depiction of “a reality that cannot actually be known, but that is always interpreted” (Charmaz, 2006, p. 22). A relativist ontology emphasizes perspective and posits the reality is comprised of various mental constructions and holds that there is no underlying truth to be found in the sciences (Annells, 1996).

### **Rigor & Verification**

Though initially thought to lack the reliability and validity typically characteristic of quantitative research, qualitative research, and grounded theory in particular, has established itself as a particularly rigorous method (Morse et al., 2002). Many respected qualitative researchers posited that terms such as reliability and validity were relevant only to quantitative, not qualitative research (e.g., Altheide & Johnson, 1998; Leininger, 1994, as cited in Morse et al., 2002). As such, the criteria utilized for this research project is *verification*, which is “the process of checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity and, thus, the rigor of a study” (Morse et al., 2002, p. 17). There are a number of components inherent within verification that will be discussed below, all drawn from Morse et al. (2002).

### ***Investigator Responsiveness***

According to Morse and colleagues (2002), investigator responsiveness “is the researcher’s creativity, sensitivity, flexibility, and skill in using the verification strategies that determines the reliability and validity of the evolving study” (p. 17). The investigator must remain open and be willing to let go of ideas and categories that do not have enough research support, regardless of how personally attached the research is to them. An investigator might be un-responsive because of lack of knowledge, adhering too strictly to instructions as opposed to listening to the data, struggling to move from specific coding to broader level understandings of the data, or working from previously held assumptions of theoretical framework. In sum, the ability of the researcher to be responsive and flexible at all stages of the research project is imperative and is an approach that was utilized throughout this dissertation.

### ***Methodological Coherence***

Methodological coherence means to ensure coherence between the research questions and research methods, and subsequently between the data and the analytic procedures. This also implores that the researcher be flexible with their methods – data might need to be treated differently, so the question might change, or the methods might need to be modified. Within the present project, the research questions were regarding processes that individuals go through. Specifically, the process that counsellors go through to provide help to a man who has experienced IPA, and the process that men go through to seek help for IPA. Thus, a grounded theory approach matched with these research aims and questions. Similarly, in order to understand these processes, I needed to hear participants stories. The nature of the project required that qualitative methods were employed in order to develop a comprehensive, in-depth understanding of the phenomenon under study. This process was dynamic, as through data collection, the research questions began to evolve. Specifically, through speaking with counsellors I began to understand this process more as a journey of “becoming.” Participants’ stories indicated that there was a process of becoming a person who provides help, rather than a process of simply providing help. Similarly, through hearing men’s stories of IPA and help-seeking, it became apparent that men do not seek help simply “for IPA.” They seek help for a variety of concerns, all which occur within the context of their IPA experience. As such, the research questions changed, to “what is the process of becoming someone who provides help to men who experience IPA” and “what is the process of help-seeking in the context of IPA.” With the evolution of these research questions, came an evolution of the interview questions, coding foci, and recruitment aims. Questions changed to focus on societal biases and approaches with this population and to recognize that people seek help for a plethora of reasons.

For Study 1, I directed focused coding on capturing all forms of help-seeking and viewed the process as occurring each time a man experiences something related to IPA that could warrant help. I also recognized that “negative cases” or “exit points” could occur within the same story for participants. They could seek help for one concern, but not another. Thus, original participants were also treated as negative cases. This altered the recruitment strategy, where recruiting negative cases was not as pertinent, and thus a decision was made to only recruit one individual who had not sought help.

For Study 2, I directed focused coding on what makes these individuals different. Why are they choosing to provide help, and how do they come to this place where they believe the help they are providing is good. The recruitment path also changed, as I realized that in order to understand how people “become” someone, I would need gather cases of individuals who have fully reached that point (i.e., who are specialized in this area of men who experience IPA). In addition, this idea of “becoming” triggered additional considerations of how this might parallel counsellors who help other stigmatized populations. As a result, I altered my recruitment plan to also include these potential participants. In sum, this project was a dynamic and quickly evolving process. I remained responsive and flexible throughout, as to ways that my research question might change, and how the data might portray something different than what I expected. I then attended to this through the aforementioned approaches and worked to ensure that methodological coherence was in place throughout.

### *Appropriateness of Sample*

This component refers to ensuring that your sample consists of individuals who will have relevant and representative knowledge of the phenomenon under study. This will then ensure efficient, and successful saturation of categories. This component also refers to ensuring that there is sufficient data, which accounts for all aspects of the phenomenon. Within this, it is essential to utilize negative cases. Further, saturating the data will ensure that there is replication in categories (i.e., that categories are seen over and over again amongst your participants). Within this project, I recruited participants who would have the most comprehensive, in-depth knowledge of the phenomenon under study. This involved men who had personally experienced IPA, and had or had not sought help, as well as counsellors who provide help to men who experience IPA, either indirectly, or in a specialized capacity. This recruitment involved the utilization of negative cases (i.e., men who had not sought help, and counsellors who worked with other stigmatized populations), in order to better understand the boundaries of the study. Both of these samples were deemed to be appropriate for the sample under study, because they effectively provided breadth and depth of data for answering the evolving research questions. In addition, categories were developed and were repeatedly seen across participants’ stories, which indicated that the results were comprehensive and complete.



### ***Collecting and Analyzing Data Concurrently***

This component involved ensuring a “mutual interaction between what is known and what one needs to know” (Morse et al., 2002, p. 18). This method is a staple of grounded theory methodologies, also known as the constant comparative method. As such, I utilized this method throughout this dissertation. I interviewed participants, coded the data, re-interviewed participants, performed additional coding, altered the interview guides, and continued in this fashion for the entirety of the project. Within this, the collection and analysis of data helped me to discover what information I still did not have, and I attended to this by both altering the interview guides and recruiting new subsets of participants in order to fill these knowledge gaps.

### ***Thinking Theoretically***

This aspect refers to focusing on how ideas which emerge from the data are corroborated by new data. This process engenders new ideas, which must then be compared and confirmed with the data already collected. Thinking theoretically is said to require a macro-micro perspective – inching forward without making cognitive assumptions, and continuously checking and re-checking the data within itself. Much of this approach was explained previously, as a component of the constant comparative method. Within this project, I was constantly memoing and conducting open and focused coding. When new ideas and categories would arise in later interviews, I would go back to initial interviews, and check to see if the newly developed categories and ideas fit.

### ***Theory Development***

This final component of theory development is to consciously move between a micro perspective (i.e., the data) and a macro conceptual (i.e., theoretical) understanding. Through this, Morse et al. (2002) note that “theory is developed through two mechanisms: 1) as an outcome of the research project, rather than being adopted as a framework to move the analysis along; and 2) as a template for comparison and further development of the theory” (pp. 18-19). Within grounded theory, a related concept known as theoretical sensitivity is also important (Glaser, 1978). This is the ability of the researcher to be sensitive (i.e., pre-held knowledge that the researcher brings into the project) to aspects of the data that might be theoretically relevant (Glaser, 1978). Despite having avoided reading the theoretical literature regarding help-seeking processes, and processes of becoming service providers, I entered this project with a knowledge of influential barriers and facilitators to help-seeking, and a knowledge of social processes. As

such, I ensured that I was both attending to the micro-level details of the data (i.e., the idiographic nature of people's stories) through performing open coding, as well as bringing in a macro-level approach, where I was comparing and contrasting across people's stories, performing focused coding, noting commonalities across participants, and focusing in on areas which might be theoretically relevant in order to develop categories. The theories were developed and were further refined through continuous comparison with other participant's stories, memoing, and theoretical sampling. This process resulted in two, fully formed theories, which were comprehensive, logical, parsimonious, and consistent, as recommended by Glaser (1978) and Morse (1997).

### **Cultural Considerations**

#### **Location**

An important aspect of this research project is the location in which these studies took place. I must note that I began this research through the University of Saskatchewan in Saskatoon, Saskatchewan, and I want to acknowledge that I lived and worked on Treaty Six Territory, the traditional homelands of the Métis nation, for the first four years of this project. For approximately the last year of this dissertation, the work was completed in Winnipeg, Manitoba, where I was placed for my clinical psychology residency. Here, I lived and worked on Treaty One Territory, the territories of the Anishinaabeg, Cree, Dakota, Métis, and Oji-Cree Nations.

Study 1 recruitment took place exclusively from across Saskatchewan. As such, it is important to acknowledge the context with which participants were being recruited and were sharing their stories. I did not exclude participants based on where their abuse or help-seeking journeys took place, but solely required that participants be living in Saskatchewan at the time of interview. As such, though many participants had resided in Saskatchewan their entire lives, some spoke of having lived in other countries and/or provinces, and thus their abuse and help-seeking experiences took place there as well. Study 2 recruitment took place across North America. Thus, I had recruited participants from Saskatchewan, as well as from across Canada and the United States. As such, the stories from my participants are reflective of a broader geographical range, as opposed to Study 1. Both studies took place in a context where settler society has been the dominant view, and colonization and inequalities remain present. As such,

the results of both studies should be interpreted with this geographical location and colonial history in mind. The impact of culture and location will be discussed further in Chapter 9.

### **Defining Culture**

Studies of culture initially originated with the field of anthropology (Tierney & Lanford, 2018). Here, “researchers studied ‘exotic’ groups that were presumed to share several features, habits, and customs” (Tierney & Lanford, 2018, p.1). Becher and Trowler (2001) note that culture involves: “sets of taken-for-granted values, attitudes, and ways of behaving, which are articulated through and reinforced by recurrent practices among a group of people in a given context” (p. 23, as cited in Tierney & Lanford, 2018). Based on this understanding, culture extends far beyond traditional conceptualizations of race and ethnicity. Rather, there are multiplicities of culture. Groups of people of (but not limited to) various ethnicity, language backgrounds, institutions, workplaces, living spaces, religions, and genders can all hold different values, attitudes, and practices. Tierney and Lanford (2018) note that one of the benefits of utilizing a cultural perspective in research, is that it “enables researchers to explore the potential for human agency” (p. 5). For example, although a once specialized practice, such as yoga, might become globally popular, individual people groups might interpret and implement these types of practices in very different and unexpected ways (Tierney & Lanford, 2018). Similarly, practices such as help-seeking and receiving, and even experiences such as IPA, can all be interpreted, felt, understood, and attended to in idiosyncratic ways, according to the cultural context within which they occur. As a result, I wanted to acknowledge the unique cultural locations that might influence the way that individuals interpret their experiences. As will be described in the discussion section, various other cultural locations exist and necessarily influence both the experiences of participants and the transferability of this research data.

However, given the settler history within both Saskatchewan and academic institutions, the importance of acknowledging the continued colonization of Indigenous peoples in particular, and working to address that in research, presented as a mainstay of this project. As a result, a strong emphasis was placed on recognizing the importance of Indigenous culture and cultural sensitivities when conducting this dissertation, and these efforts are described below.

## **Indigenous Advisory Committee**

This dissertation journey has been incredibly eye-opening and meaningful for me, particularly with regards to my goal of conducting this research in a culturally appropriate and considerate way. Notably, studies suggest that Indigenous men may have an elevated risk of IPA, with prevalence rates that are 2 to 3 times the rate of non-Indigenous men (Brzozowski, 2004; Rennison, 2001; Trainor & Mihorean, 2001). As a result, my dissertation committee suggested that I put strategies in place in order to ensure that my project was done in a culturally appropriate way. This came in the form of developing an Indigenous advisory committee (IAC), with whom I consulted regarding developing this research and interviewing participants who were Indigenous. I am immeasurably grateful to have had Drs. Dick Katz and Rose Roberts as members of my IAC for this dissertation. The wisdom, kindness, and patience I received from them this during this process is unparalleled.

Based on this knowledge of the rates of IPA amongst Indigenous communities, admittedly, I was nervous to start data collection for this project. This came from a recognition of the hurt and trauma that my ancestors, along with the general academic community, have caused Indigenous Peoples. This nervousness was compounded further through knowing how this history has introduced violence and intergenerational trauma which has unquestionably contributed to individuals' experiences of IPA. Undeniably, a very significant portion of my research topic is interwoven with Canada's history of colonization (Brownridge, 2003). As such, I deeply wanted to ensure that I was conducting this research in way that was culturally appropriate and respectful with Indigenous participants.

## ***Methodology***

There were many obstacles and decisions presented to me that I felt ill-equipped to handle on my own. My IAC responded to my qualms and fears with grace and encouragement. Prior to recruiting participants, I sought their advice regarding a number of logistical aspects of my project. First, I inquired as to whether it would be appropriate to aim to specifically recruit Indigenous participants (i.e., given the high rates of IPA in Indigenous communities, and wanting to ensure that this study was "representative" of Saskatchewan, and that Indigenous voices were heard). We discussed this and spoke of the inherently top-down nature of academic research. It would not be appropriate to enter into Indigenous communities with an already-formulated research project, that involved no consultation with the community regarding what

they believed was important. My research advisor concurred with this. As such, direct recruitment (e.g., on Indigenous reservations or targeting Indigenous potential participants), would not be appropriate. However, if I appropriately recruited across Saskatchewan (e.g., in places that were accessible and culturally appropriate), then Indigenous participants would be able to self-select, thereby indicating that this was an important issue to them. Thus, we made the decision to limit recruitment to service provision locations and PAWS (detailed below).

A second issue that I consulted with my IAC about was the importance of asking participants about their cultural location and impact of their culture on their experience. I was advised that although this information is likely important and recognizing the impact of colonization and culture on people's experience is imperative, this is not an appropriate question to ask solely of Indigenous participants. Furthermore, because culture and colonial history is not the foci of my dissertation, it would be a pillaging of knowledge and effort to ask questions regarding this, when it is not the focus of my dissertation. I was also advised that if cultural location and experience was truly an integral part of participants' experiences, then this information would come out of the data regardless, I should not have to seek it out and ask directly about it.

My IAC provided guidance regarding the logistics of providing a culturally appropriate research experience to participants. Our protocol was that during the screening process (detailed below), I would ask participants about their ethnic and cultural background. I would then ask about their connection to their cultural background, if it was an important component of their lives, and if there were any cultural supports that they thought might be helpful for them during the research process. From there, if a potential participant indicated that they identified as Indigenous, then I consulted with my IAC regarding next steps. In total, I recruited one individual who identified as Indigenous. Thus, I consulted with my IAC, and they suggested that I offer the option of in-person or telephone interviews, as well as offer tobacco as a token of gratitude to this participant.

Not only did my IAC offer concrete guidance and direction regarding decolonizing my research, they also provided a space to reflect on my approach, and to consider decolonization of research from a more holistic perspective. I learned to approach my research from a place of relationship, and to view this project as a product of that relationship. I further developed an understanding of research not as a knowledge gathering tool, but as a relational effort to

engender change. I am aware that a top-down research approach such as mine, where I recruit participants to participate in a study that is guided by my own research questions and perspectives on what is important, is an academic endeavour, and is not necessarily a culturally appropriate approach. As such, I felt compelled to listen to what participants themselves viewed as important. What areas of help-seeking and help-providing have been particularly salient to them, and what is the change that they want to see? For myself, I believe that grounded theory is the best method through which to do this. These theories were formulated from participants' experiences and their stories; it does not exist outside of them. However, theory is nothing unless we are able to put it into practice. What I learned from my participants is that they want change. As such, I believe that it is important to pay ample attention to the ways in which the results of this project can be translated into action, and this was made to be a strong focus of my discussion section. It is in this way that I feel I am able to appropriately and respectfully center my participants' voices in this research project.

### **CHAPTER 3: STUDY 1 METHODS**

Men experience IPA at alarming rates and can incur significant and deleterious mental and physical health effects from this abuse (Carbone-Lopez et al., 2006; Coker et al., 2002, 2005; Stitt & Macklin, 1995; Walker & Gavin, 2011). Yet, a plethora of evidence suggests men are reluctant to seek help for a variety of health issues, including IPA (Addis & Mahalik, 2003; Barrett et al., 2020). Furthermore, when men do make the decision to seek help, they are frequently met with discriminatory reactions from service providers (Bates, 2019; Brogden & Nijhar, 2004). These reactions can have particularly negative consequences for men who experience IPA that might further compound the direct physical and negative consequences of the abuse (Addis & Mahalik, 2005; Eckstein, 2009).

Researchers have thoroughly investigated men's experiences of abuse, experiences of seeking and receiving help, and potential barriers and facilitators to help-seeking. Much of this research has been qualitative and thus has elucidated the lived experiences of IPA, thereby providing us with an in-depth understanding of these experiences. Furthermore, various researchers have endeavored to understand the theoretical underpinnings of help-seeking. This pertains to both general help-seeking and help-seeking for IPA specifically. However within this IPA-specific help-seeking literature, no theories have been developed from the lived experiences of those who have experienced IPA, and moreover, none have been specifically developed for men who have experienced IPA. Thus, a gap remains in the literature regarding an inductive approach to understanding the journey that men go through to realize that they require help, decide where and how to seek help, how they experience those provisions of help, and how this might eventually lead to healing from abuse. As a result, for Study 1 I used a bottom-up approach (i.e., a grounded theory methodology) to develop a theory regarding the process of seeking and experiencing help amongst men who experience IPA. As previously discussed, research suggests a number of factors likely contribute to this process (e.g., masculinity, previous negative help-seeking experiences). However, my dissertation topic was explored in a non-directive manner. Participants were allowed to tell their stories as they see fit and were encouraged to speak about what facets of their abuse and help-seeking experiences they believed were important and pertinent to the process of seeking and receiving help for IPA.

#### **Procedure**

I obtained approval from the U of S Research Ethics Board (REB) to conduct my

research study. As per theoretical sampling, I submitted amendments to the REB as needed. Participants were first screened to determine their eligibility for this study (see Appendix A.1). During the screening interviews, I asked participants to briefly describe their abuse experience in order to determine eligibility. I also asked participants demographic questions (see Appendix A.1) in order to determine eligibility, determine whether my Indigenous advisory committee should be consulted, and to eventually describe my overall sample. If they were met eligibility criteria, participants were provided a consent form prior to the interview (see Appendix A.2 & A.2.1), and verbal informed consent was provided by all participants. All interviews were audio-recorded. On average, all interviews lasted approximately 70.4 minutes (*range* = 45 to 102 minutes). At the end of interviews, participants were then debriefed and were provided a debriefing form (see Appendix A.7) and were thanked for their time. All participants consented to be contacted for future interviews if needed.

## **Recruitment**

I recruited participants through a variety of outlets. First, I utilized social media, whereby I posted recruitment materials on our research lab's Facebook page as well as my own, and allowed others to share the materials on their own Facebook page. I also contacted various service provision locations via Facebook, and requested permission to post the recruitment materials on their Facebook pages. I further contacted various locations across Saskatchewan where men who experience IPA might be likely to seek support and services (e.g., shelters, psychologists' offices, violence prevention programs). I sent emails to the administrators at these locations, and included recruitment materials in these emails, which had our lab's telephone number and email address. I asked these administrators to display the recruitment materials up in their place of work. The locations which I contacted will not be named, in order to maintain confidentiality. Additionally, I posted the recruitment materials for this study on PAWS, which is a website for students, staff, faculty, alumni, and other members of the University of Saskatchewan community. To inquire and/or sign up for the study, potential participants could send an email to a secure, U of S email account, or contact our lab telephone. Participants were then contacted by telephone in the VideoTherapy Analysis Lab (ViTAL) in the Arts building at the University of Saskatchewan.



## Participants

Thirty-two participants contacted me to express interest in the research project. 16 of these participants did not reply to my response email, and thus were removed from the sample. Eight of these participants were screened but did not meet eligibility criteria (seven did not seek help, one had not experienced IPA). Of these who did not meet criteria, two participants were asked to participate in the study due to their eligibility as negative cases<sup>8</sup>. The remaining six were informed that they did not meet criteria for the study. Eight participants were screened and met full criteria for participation. Thus, the final sample consisted of 8 individuals who self-identified as male, who had been abused by an intimate partner who was a woman, and who had sought formal help. In addition, the two negative cases also self-identified as male, had been abused by an intimate partner who was a woman, but did not seek help (i.e., total = 10 participants).

In order to ensure maximum confidentiality given the size of the community where local participants were recruited, demographic information for age and ethnicity is removed (Allen & Wiles, 2016). Participants reported experiencing a range of abusive experiences, including sexual, physical, financial, psychological, and verbal abuse. Seven participants reported that they had children with their abusive partner. All participants stated that they were no longer in a relationship with the abusive partner. Length of the relationships ranged from approximately 6 months to over 20 years. Types of relationships varied, and included dating, marital, and common-law relationships.

### *Types of Help and Reasons for Seeking Help*

Participants sought help from a variety of service providers, at various stages during and following their abusive relationship, and for an assortment of reasons. The types of service sought included: police, nursing, individual counselling, couple's counselling, child protective services, and legal help (i.e., lawyers and mediation). The reasons for seeking these services included: concerns of personal safety, concerns of the safety of their children, physical injuries, custody concerns, mental health difficulties, decision-making relating to the abusive relationship, and couple's counselling for a current, non-abusive relationship.

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<sup>8</sup> Participants not meeting specific inclusion criteria or who are different from the remainder of the sample, and which allow researchers to assess the boundaries of developed categories and confirm hypotheses regarding the process men go through to receive help for IPA (Booth et al., 2013; Creswell & Miller, 2000).

## **Transcription**

Interviews were transcribed by either me or a trained research assistant who had signed a confidentiality agreement. Interviews were transcribed to include gerunds, pauses, and emotional content. These transcripts were deidentified and saved in a Word document on a password-protected computer, on a secure lab drive. From there, transcripts were printed into hardcopies, and stored in a binder, which was kept behind three locked doors.

## **Data Generation**

All participants were contacted for interviews on a secure telephone in the aforementioned lab space. First, potential participants participated in a screening interview (Appendix A.1), and if they met criteria, or were chosen as a negative case, participated in the full interview (Appendices, A.3, A.4, A.5, and A.6).

In alignment with grounded theory methodology, the data was generated in multiple phases, each consisting of interviews and concurrent data analysis. Phase 1 consisted of conducting interviews with four participants. To begin the initial interview, all participants were provided with the open-ended question: “I’d like to start by asking you about your relationship with this individual. I’d like to better understand the context that this experience occurred in. Feel free to start wherever you’d like with this, and to share as much or as little detail as possible, whatever you are comfortable with.” Next, I interviewed Phase 1 participants using a semi-structured interview format (see Appendix A.3).

Phase 2 involved conducting follow-up interviews with a subset (i.e., two) of the initial four participants. The follow-up interviews were conducted with the intention of gaining further detail from the participants about their specific experience, specifically about the codes that were arising as significant. Due to the nature of these interviews (i.e., to ask specific follow-up questions regarding their personal experiences), interview guides were not created.

Phase 3 involved conducting interviews with two new participants (see Appendix A.4). These interviews were performed with the intention of asked more focused questions regarding the codes which appeared significant, as well as to gather data about others’ experiences in order to work towards saturation of the data.

Phase 4 involved interviewing two additional new participants. In keeping with theoretical sampling, in addition to the previous questions I also asked about feelings of ambivalence regarding seeking help in order to further clarify the model (Appendix A.5), as this

had come up as a potential major category during the previous phase of analysis. Finally, I discussed components of the emerging grounded theory model with participants and used this data to further confirm and/or modify existing codes, categories, and the ordering of phases.

Phase 5 involved interviews with the two negative cases chosen because they indicated in the screening interview that they had not sought professional help for the abuse. At the time of interview, one of these participants had made the recent decision to seek professional help. Thus, he was able to provide very detailed information regarding this decision. The second participant still had not sought professional help. Interviews with these participants were conducted with a focus on their decisions not to seek help, and regarding what would have had to be different in order for them to seek help (Appendix A.6). This data was used to determine the boundaries of the categories, and to provide insight regarding exit points along the process.

## **Grounded Theory Analysis**

### ***Open Coding***

I first read through and highlighted sections of the initial transcripts, to identify areas which were pertinent to my research topic (i.e., help-seeking). Next, I performed “open coding” where I assigned codes to the pertinent transcript areas. These codes involved ascribing “action” based words and/or phrases to sections of the text, in order to summarize the main point. These codes often included the specific verbiage used by the participant. Next, I reviewed the transcripts and their codes, and looked for similarities across interviews. Throughout this process I wrote memos regarding similarities between participants, common codes that were recurrent, and my thoughts and feelings about the process. This memoing process helped me to identify a number of codes that were recurrent across participants, and I kept a running list of these.

### ***Focused Coding***

The second stage of analysis involved focused coding. Here, I identified the codes which appeared most frequently, and used them to establish linkages between other codes. I read through all of the transcripts and took note of what themes/codes were arising consistently across participants. I paid close attention to what codes appeared to be pertinent and necessary for participants in their help-seeking process. I began with the first four participants’ interviews and began identifying codes which could be subsumed or combined under a larger, umbrella term (i.e., a category; Charmaz, 2008). This was completed in tandem with coding the two follow-up interviews. Throughout this process I wrote memos regarding which codes should be combined,

and initial thoughts regarding category names. This process of memoing allowed me to track my thought process and to see how the categories slowly developed. From this process I then had developed a list of categories and memos about these categories, which enveloped the various codes that I had initially created. I then went through the Phase 3 interviews and performed further focused coding. Here, I was looking specifically for evidence to confirm the existence of these initial categories that had emerged, and to provide additional context and depth to these categories. Phase 4 and 5 interviews were coded in tandem. This process involved looking through the transcripts and further applying a focused coding approach alongside consistent memoing. These interviews were used to further clarify and conceptualize the initial categories. By the end of this iterative process, I had developed a number of theoretical categories which encompassed the initial open codes. Through memoing and constant comparison of the data, these theoretical categories were formed into a synthesized theoretical process regarding men's journeys towards seeking help.

### ***Theoretical Saturation***

Data generation and analysis were conducted iteratively until theoretical saturation was reached. This is “the point in category development at which no new properties, dimensions, or relationships emerge” (Strauss & Corbin, 1998, p. 143). As noted above, data was generated in five iterative phases. Following Phase 3, I began to suspect that I had reached theoretical saturation. I started questioning whether theoretical saturation had occurred because there did not appear to be any new information coming from the data (Morse, 1995). For myself, I was no longer surprised at the stories that participants were sharing, or at the answers that they were providing, because I felt like they were *familiar* – I had heard this information from previous participants. During the coding process as well, although I was attending to possible divergent areas, or areas of difference, they were not arising – the information began repeating itself. However, in order to confirm this, I interviewed two new participants, and performed focused coding on this data. Following these interviews, no new information was arising. Next, I performed interview with two negative cases (i.e., participants who had not sought professional help), which is an additional step to ensure theoretical saturation (Morse, 1995) Focused coding was conducted with these interviews well, and they were used to determine the boundaries of the categories, as well as to provide further evidence regarding exit points along the model. Constant comparison was used between and within participants throughout this process, alongside

memoing, and consultation with my research supervisor. As noted above, saturation of data (Robinson, 2014) appeared to occur around participant six (interview 8).

A number of other considerations were made when determining theoretical saturation. For one, my sample was cohesive and homogenous (Morse, 1995). Specifically, my sample consisted of men, in Saskatchewan, who had experienced abuse from a female partner, and who had either sought or not sought help. According to Robinson (2014), this sample has Demographic homogeneity (i.e., gender of self and partner), Geographical homogeneity (i.e., Saskatchewan), and Life-History homogeneity (i.e., history of abuse). Morse (1995) notes that homogeneity of your sample will lead to quicker saturation. There are, however, challenges inherent in using a heterogeneous sample, such as a trade-off between heterogeneity and homogeneity of samples (Robinson, 2014). Notably, that homogeneity can reduce the generalizability of your findings (Robinson, 2014). However, others argue that having too heterogeneous of a sample means that findings will not be applicable to real-life settings, and that the sheer diversity of data may lessen the likelihood of finding deep and consistent themes during analysis (Robinson, 2014). Thus, Robinson (2014) suggests that “all researchers must consider the homogeneity/heterogeneity trade-off for themselves and delineate a sample universe that is coherent with their research aims and questions and with the research resources they have at their disposal” (p. 28). For myself, limiting the sample to men in Saskatchewan allowed me to arrive at conclusions regarding the appropriateness of services here, in our province, and thus make recommendations that would be appropriate, specific, and useful. Furthermore, homogenizing the sample by only including abuse by a female partner was done in an effort to ensure that important aspects of intersectionality were not missed. The homophobic responses of services providers towards men that are seen in the literature (Brown & Groscup, 2009), would not receive as in-depth of an analysis as deserved, and the diversity of data may lessen the likelihood of finding meaningful, consistent themes (Robinson, 2014). Yet, this homogeneity was balanced by including a range of ages, types of abuse, types of help-sought, and diverse ethnicities, which allows for a heterogeneity of sample that still encourages applicability in a variety of cases.

Furthermore, my sample was tailored to a very specific research question, and I utilized theoretical sampling, both which are important components to facilitate saturation (Morse, 1995). This sample holds the precise knowledge that is necessary to answer the question of men’s

process of help-seeking in the context of IPA, which will further facilitate saturation. The use of theoretical sampling further ensured that the sample continued to be relevant to the research question and the evolution of the data and analysis. This meant that I was continuously recruiting participants who were able to provide in-depth perspectives regarding my research questions. Furthermore, by the completion of data collection, I had a resulting theory that was comprehensive, understandable, and did not have gaps. It helped to explain the phenomenon under study, it helped to make predictions regarding men's behaviours throughout the process, and it made sense considering previous literature - all which Morse (1995) notes are important indicators of saturation. This knowledge, and its overlap with the saturation and sampling literature (Morse, 1995; Robinson, 2014), allowed for confidence in my suspicion that saturation was reached.

Based on my previous description of theoretical saturation, my formal theoretical saturation check involved a number of components. First, I reached a point, as noted above, where no new codes were arising from the data. Second, I reviewed the theoretical categories, and ensured that they complete. This was done through formally writing up the results section and determining whether the categories and their inter-connections were comprehensive and understandable. During this review of categories I also ensured that the theory was comprehensive and provided a clear description of the process that I was investigating. I further acknowledge that I had reached a point of feeling like I understood participants and their stories. Last, I conducted a check of the data, to ensure that all participants' voices were captured within the higher-level theoretical categories (see Table 3.1).

## CHAPTER 4: STUDY 1 RESULTS<sup>9</sup>

### Overview

Results of the grounded theory analysis depicted a clear process through which men proceed in order to seek help. The overall process (see Figure 4.1) is comprised of five phases that individuals move through each time there is a potential opportunity for seeking help: 1) Experiencing Distress/Abuse, 2) Recognizing Severity, 3) Realizing Limitations, 4) Deciding to Seek Help (Sub-phases: a) Exploring Options and b) Weighing Pros and Cons), and 5) Obtaining and Engaging in Help. Notably, participants go through this process *each time* that they have an abusive experience, or experience distress related to the abuse, regardless of the reason for seeking help or the type of help sought. Thus, this theory considers the multi-faceted nature of help-seeking – it occurs at a variety of stages, for a variety of reasons, and with a variety of professionals. The individual phases and the sub-processes within them are described below. Furthermore, I clarify various challenges (i.e., “exit points”) which prevented participants from moving through the model. These exit points help explain why some participants were able to move through a phase, while others were not.

#### **Phase 1: Experiencing Distress/Abuse**

For initial “entry” into the model, all participants had experienced something significant that could be considered abusive, or experienced distress that was related to the abuse. This stage involved a plethora of experiences. Participants spoke of physical, verbal, emotional, psychological, and financial abuse against themselves, abusive behaviours directed towards them that placed their children in danger, as well as abusive behaviours directed at their children. The distress that they experienced as a result of these abusive behaviours included both physical harm (e.g., stab wounds) and mental harm (e.g., depression). Participants described these experiences as both isolated events (e.g., physical abuse from partner that placed child in danger), and events that built up over time (e.g., negative mental health consequences of numerous episodes of abuse). Example quotes include: “She...got married...and they were trying to force me to sign adoption papers” and “She threw at 12-inch chunk of glass into the back of my arm.” It is important to note that this phase label refers solely to the experience, not necessarily to the

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<sup>9</sup> The five phases and their labels will be discussed below in general terms. However, it is imperative to note that each individual’s experience of journeying through these phases will be unique and idiographic. Experiences and relevance of these phases will vary per each person’s locations of difference. This will be expanded upon in further detail in Chapter 9.

participants' recognition of the experience as abusive. That is, participants could still enter this model without realizing their experience could be defined as abuse.

## **Phase 2: Recognizing Severity**

In order to proceed through the help-seeking model, participants had to develop personal awareness that what they were experiencing was severe. The process of development of this awareness varied per participants, and the threshold for severity was highly idiographic. At times it was cumulative, where it took many instances of distress and abuse for the participants to realize that what they were experiencing as severe. Typically, this was explained through variants of "the straw that broke the camel's back." For example: "And that's when I started really thinking like wow this has been going on for a very long time and it's not getting any better, if anything it's getting worse. And that's when I seeked [sic] out the [counselling service] to really talk about like what do I do going forward from here." However, for other participants this severity was recognized immediately following an instance, for example a significant physical altercation or a time when their children were placed in danger. For example: "Something happened and she got really mad at me, and it was the first time she'd ever like been physical with me...I was scared. I was scared because she was this sort of culmination of her losing control of herself. And so uhm, I ended up going to the police." With these, thresholds for Recognizing Severity appeared to be influenced by the type of abuse. Particularly if the abuse involved people other than the participants (e.g., children), then severity was more quickly recognized. Furthermore, instances of physical abuse were more quickly recognized as severe, whereas verbal and psychological abuse typically took participants longer to recognize severity.

Participants described developing their own awareness of severity through a variety of means. One mean was through the feedback and opinions of others: Social support arose as particularly influential during this point, such that having external validation regarding the significance or severity of the abuse was very helpful for participants to recognize the severity themselves. For example: "when I had started talking to my friends about [the abuse]...that's when it dawned on me, oh this is a lot worse than I thought it was." Another means of recognizing severity was receiving factual information about IPA from sources. For example, outside information, such as descriptions of abuse in advertisements, were also important pieces of validation that influenced participants' perceptions of the severity of their experiences. For example: "[I opened a magazine] and it said 'oh are you in an abusive relationship' and I kind of



had been reading over all the things and I was like wow wow, like, 9 out of 10 of these apply to me.” For others still, they recognized the severity of the situation on their own and did not require outside perspectives.

Within this theme, participants also spoke of making excuses for their partners. These excuses included thoughts of blaming oneself, belief that the abuse was normal, and explanations regarding their partner being under stress, or struggling with their mental health. An important part of recognizing severity, thus, was recognizing that they had been making excuses for their partner. This took the form of realizing that the abuse was not their fault, realizing that what they were experiencing was not normal for a relationship, and realizing that what they were experiencing was not acceptable, regardless of their partner’s mental health or level of stress. For example. “[that was] the first time I really thought about it in terms of that timeline, of all the excuses over the years that I’ve been giving.” Another participant spoke of the normalization of female-perpetrated abuse in society, which makes it difficult for men to recognize that what they’re experiencing is severe. Specifically: “It’s very normalized...that men just like take it, like you just gotta deal with it man, like she’s a little bit crazy but it’s worth it, you know.”

Some participants exited the model during this phase when they did not recognize that their situation was serious. That is, participants did not continue on through the model, and thus did not receive help for that instance. For some, this occurred because their relationship entered a phase where things were no longer tumultuous: “[thinking] you know it’s not necessary to do this cause look we’re fine now.” Others did not see the situation as severe enough to warrant help: “It would have had to have been like serious damage, or like, as weapon...it would have had to have been more severe for me to involve the police.” For others, they struggled with numerous societal scripts regarding “men cannot be abused,” “this is normal,” and “this is my fault,” which made it more difficult for participants to recognize the severity of the abuse that they were experiencing. For example, one participant said: “I didn’t think it was very severe, or valid, or uhm, I fell into the ‘men can’t be abused’ mental trap that I think too many people buy into.” These societal scripts appeared to be significantly influenced by both internal and external pressures of essentialist masculinity. It appeared that the stronger these societal scripts were for participants, the more difficulty they had completing this phase.

### **Phase 3: Realizing Limitations**

Participants who experienced Realizing Severity and moved forward beyond this stage in the model then had to recognize that they were unable to handle the severity of the distress or experience on their own. This phase is the point where participants recognized that they were limited in their means to help themselves and required additional, outside help. These limitations involved physical limitations (e.g., fear of the partner), emotional and mental limitations (e.g., inability to cope with the mental health repercussions of the abuse on their own), and limitations of knowledge (e.g., lack of knowledge regarding custody rights). For example, “She started screaming about things, throwing things across the room, breaking things, where I I couldn’t talk to her. I couldn’t do anything because it would be physical, so I had to call the police, to have her taken out of my house,” “It was very bad, so I ended up going to a counsellor cause I just didn’t know what to do with it... I felt very helpless. I’m trying desperately trying to fix this, and obviously, I can’t,” and “First I wanted to get advice because I didn’t know what to do.”

During this phase, some participants reported also trying initially to deal with the abuse or distress on their own. For example, one participant used an analogy of a vehicle: “I wanted to make sure that it was the right move... it wasn’t my first instinct to do, cause I’d rather, just you know, if it’s something that I could just myself remedy, then I would try to remedy it....I guess, I’ll use a car. Okay my car’s broken, I’ll see if I can fix it myself. And once I determined, nope, can’t fix it myself, then I would, better get somebody to help me.” This process was helpful for some in realizing that they could not deal with the issue on their own, which helped them to successfully resolve this phase on the model.

Participants who recognized that what they were experiencing was severe, but who had the means to help themselves (e.g., recognized abusive nature of relationship, had the financial means, so moved out of their house), did not seek help and thus exited the model at this point. For example, “Thankfully like...I’ve been in a couple tussles in my day, so I know how to block...a hit. But if she caught be in the face or something, then that maybe woulda influenced my decision.”

### **Phase 4: Deciding to Seek Help**

After realizing their limitations/that additional help was needed, participants then engaged in a process of Deciding to Seek Help. Within this decision, however, there were sub-processes that were occurring. Specifically, participants oscillated between the subprocesses of

Exploring Options and Weighing Pros and Cons. The driving force behind this oscillation is Ambivalence: participants were unsure whether or not they should seek help for their concern, and only once this Ambivalence was overcome, could they make that final decision to seek help. Participants experienced this Ambivalence for a plethora of reasons (e.g., concerns about stigmatization, masculinity scripts, disengaged in the process). Through the subprocesses of Exploring Options and Weighing the Pros and Cons of seeking help, some participants were made aware that help was available and would be beneficial for them and was the best choice and sought help. Others found that help was not available, that the help available would not be beneficial, or that the cons of seeking help would outweigh the benefits, and thus exited the model.

### ***Subphase: Exploring Options***

This sub-process involves participants exploring what options are available for them to seek help from. This took many forms, including scanning their environment, speaking with friends and family, searching online, and meeting with the service providers for an initial intake session. For example: “I’d go on the websites and like see reviews and look up their...Facebook...and like what strategies they employ, like how they kind like guide themselves and how their sessions are set up. So I have like a very specific criteria that I was looking for.” However, if participants were not aware of help options or did not believe that there were services available for their specific concern, then participants would exit the model, and would not seek professional help. For example “I didn’t know of any therapists or counsellors that existed in that environment, so I wasn’t really made aware of any resources, and...I guess I also didn’t know...who I could talk to really.” However, when participants explored options and found that there were services readily available, this helped to resolve Ambivalence. For example, one participant noted: [I sought help because] at [university] I see [services advertised] everywhere, and I’m really grateful for that.”

Furthermore, for some participants, Exploring Options involved contacting friends or family who were service providers themselves (e.g., social work, police officer), and asking what their options were. For example: “I called a friend of mine, who’s a police officer, and I’m like hey man, so she stabbed me, what...do I do...” This act appeared to pose a dual-purpose – participants received validation from professionals regarding the appropriateness of their situation for seeking help, and elicited advice regarding what help options were available to

them. Participants then were either told what help was available for their concern or were told that help was not available and would decide to seek or not seek help accordingly (i.e., would exit the model)

With Exploring Options, participants also spoke of evaluating whether the help available would actually be helpful for them, and/or appropriate for their current situation. Hearing outsiders' perspectives, particularly recommendations for services from friends and family that help was worthwhile, was a particularly poignant experience, one that often resulted in participants' seeking help, for example one participant noted that "Th[e] place [he] had been came highly recommended." At times, participants also questioned the appropriateness of help for their specific situation. Some participants would get to the point where they were making the decision to seek help but would start to experience ambivalence regarding whether their situation was deserving of help. For example, "When I started with the therapy I'm doing now...I was so worried like the first day that...they were gonna ask me what was going on, and I would tell them, and then they would say, oh no, not good enough, or not bad enough." Although this participant had recognized that their depressive symptoms were severe, they still questioned whether they were deserving of help.

At times, participants decided that help would not be useful for them and would exit the model. This decision was typically influenced by information gathered from others: "...[friend who is a police officer says] yeah man if we show up you're probably getting taken away, when you go to court, she not gonna get found guilty, you know, so you'll probably end up doing time for getting stabbed," as well as preconceived notions of help: "I think it's something that I always balked at in the past...like well it's not really going to help, how is it going to help," and opinions based on previous help-seeking experiences: "[after discussion of police and social services not taking him seriously] It took a while for me to actually like go seek help for myself [again], because I felt like nobody would listen to me."

In addition, participants would explore their options by attending an initial session with a service provider, typically an intake session. Here, they had not yet obtained and engaged in help, rather they appeared to still be Exploring their Options, by evaluating an initial appointment with a service provider. Here, participants described numerous instances of first contact with service providers where they realized that that help would not be effective, and therefore did not engage with the help. For example: "I went to a couple sessions with uhm, two

different counsellors, but just didn't like their approach, I just didn't click with them" and: "I just felt like attacked. Like I couldn't even like say my side like he was too busy telling me things...I was cut off quite a bit. Like I couldn't get my full like thoughts out, and what he said did make sense, but it was like stuff I already knew. I was probably worse off almost. So I never went back."

### ***Subphase: Weighing the Pros and Cons***

In this sub-phase, participants weighed the benefits and consequences that might accompany a decision to seek help. Each participant had a different experience of this process, and this was not always a conscious experience. Further, each type of help brought with it a different set of pros and cons. For example, one participant, when talking about going to counselling stated: "I think it's that kind of thing where knowing that there isn't a severe consequence [for my partner] made it easy for me to talk about it, just cause there wasn't any immediate, like, danger to anybody." Another participant talked of his feelings of being torn between seeking help and not: "We're supposed to endure stoically, because we're definitely not gonna call the police. Because there's this other element, like I'm supposed to protect my partner, if I charger her with assault, right, well I'm doing anything but protecting her, I'm tossing her into the system. Right, regardless of what abuse I take from her, I am supposed to stoically endure and protect her from danger. Well how do I do that when she is the danger?" For him, this was an exit point, because the cons of seeking help (i.e., "tossing her into the system"), outweighed the pros of the help that the police would provide. Still others talked about the difficult decision between help, and enduring society's perceptions of them: "if you call the cops and pursue legal action...against your...girlfriend...like in a city like this, like it's too small...everyone will know, and you'll be stigmatized and ostracized forever." An additional component of this phase involved considering the cost/benefit of services. For example: "It just like, is it worth it. Am I going to get my money's worth is the best way to put it, right. If I'm going to go spend \$100 an hour, is it going to be worth it. Am I actually going to get something out of it?"

## *Ambivalence*

As noted in Figure 4.1, Ambivalence is not a sub-process, but rather is an enduring feeling that occurs throughout the sub-processes described above. It is only once this Ambivalence is resolved, that participants were able to make the decision to seek help. Participants' feelings of Ambivalence were influenced by plethora of factors. First, participants spoke of an uncertainty regarding whether help would be beneficial for them. Within this, there were questions regarding whether their situation was worthy of or appropriate for help, as well as questions of whether help would actually be worthwhile. Questions of the beneficial nature of help were significantly influenced by participants' past help-seeking experiences. In particular, having positive help-seeking experiences previously was influential in tipping the scale towards a final decision to seek help. With these positive experiences, they were more likely to be already aware of available services, and thus their processes of Exploring Options was shortened. Conversely, if participants had negative experiences with service providers previously, then they were more likely to feel unsure about whether future help will be worthwhile, and oftentimes would exit the model.

Second, participants experienced Ambivalence influenced by societal masculine scripts. They reported questioning whether they should just "suck it up," and spoke of concerns about being stigmatized and ostracized for seeking help for abuse from a female partner. These too presented as reasons for participants to exit the help-seeking model. In addition, participants spoke of worries regarding repercussions for their partner. They described a desire to protect them, and related that this was occasionally a reason why they decided not to seek help (i.e., an exit point). Participants also spoke of Ambivalence regarding whether their situation deserved help. As noted above, this was not a question of the severity of their experience, but rather of the appropriateness of their situation for help.

At times, participants went ahead with obtaining help (Phase 5), but either did not follow-through, or did not engage with that help. This can be interpreted as an improper resolution of Ambivalence. At times, this was due to participants not yet being ready to change: "Not that they were a bad counsellor at all, it's just I had my own...like mental blocks with it." With other participants, this was because their "ambivalence" was resolved by an external force (e.g., a partner or family member taking them to counselling): "I wasn't opposed to [help] 100%, at the same time I was like emotionally hurt too so that's what made me second guess it. But yeah, I

was kind of taken there by my [family], [they] were very adamant about going there.” This participant did not end up following up with the help that he sought. Another participant spoke of going to counselling because of a family member’s encouragement, and how he did not feel like he engaged fully in therapy: “I kind of almost wish that I’d opened up a little bit more about...some of that stuff...[I held back because you] try to have a certain level of respect for someone that’s the mother of your child. And...I just didn’t really see that it was going to change anything.” In both of these instances, external forces influenced their decision to seek help, and participants did not fully engage and obtain the help that they sought. As such, these were identified as instances where participants technically exited the model, despite having physically sought help.

### **Phase 5: Obtaining and Engaging in Help**

In this stage of the model, participants actively obtained and engaged in help. This involved directed, intentional acts of contacting service providers. This phase was overcome quickly, as once participants had resolved their Ambivalence and decided that help was available and would be beneficial, they immediately then sought out that help. Specifically, participants sought help for anxiety, depression, and self-worth concerns that they viewed to be a result of the abusive relationship, custody issues, physical injuries, concerns for children’s safety, issues in new relationships, questions about relationship patterns, and concerns of personal safety. In this stage, participants also received the help that they sought. This involved experiences like fully engaging with police services, following through with a report to child protective services, or engaging fully with the therapist from whom they sought help. However, participants described a broad spectrum of experiences with counselling services, police officers, health personnel, the legal system, and child protective services, some neutral, positive, and negative.

During this phase participants described a number of positive experiences. This looked like receiving helpful services for their mental health, encountering patient and understanding police officers, and receiving helpful legal advice. For example: “I also went and saw a lawyer...and it was more just like a legal advice type session, and you know going in with a butt-load of questions, like can she do this or that, can she- what happens...I think that’s maybe one reason I didn’t need as much counselling is cause I, you know got some good answers, and...just knew what the boundaries were,” and “[discussing a therapy experience] It ended up being really good. And they, like kind of came in and...just asked you know about my day and what my goals

were and kind of that, and then we talked about it and there was no judgment...and I just got accepted, and then we started working together.”

Participants also spoke of seeking out and engaging in the help but having negative experiences with that help: “I went to the hospital and they said hey what happened, and I said oh my girlfriend stabbed me, and they’re like okay.... They didn’t ask me if I wanted any, you know to to make a police report, they didn’t ask anything,” and “[discussing counselling services] Like why am I sitting here wasting my time if you’re literally just...each time it was, all it was was very short, very brief, seemed her biggest thing was ‘you need to read all these things online.’ I’ve done my own reading, where I don’t think I can fix it myself, or I’m in need of help, so...essentially I viewed it as being turned away, you know, to just go out and keep doing it own your own. I’m not sitting here to do it on my own, I’m sitting here because I’m wanting you to help me.”

With those who had negative experiences with help, although they would have technically progressed through the entirety of the model, these negative help-seeking experiences then acted as a significant component of the Weighing Pros and Cons stage, if participants were to re-enter the model for a separate abusive or distressing experience. Specifically, these negative experiences would exacerbate the Ambivalence that they felt about seeking help the next time, and at times would cause them to exit the model. For example: “I’ve kicked the can enough times now that it’s just kinda shrugging my shoulders and being like well, I’ve been shown that it’s not really useful.”



## **CHAPTER 5: STUDY 1 DISCUSSION**

Results of my grounded theory analysis depict a clear process that men go through each time that they seek help for an experience related to their abusive relationship. This process is comprised of five phases: 1) Experiencing Distress/Abuse, 2) Recognizing Severity, 3) Realizing Limitations, 4) Deciding to Seek Help, which involves two sub-phases: a) Exploring Options and b) Weighing the Pros and Cons, and is driven by an overarching experience of Ambivalence, and 5) Obtaining and Engaging in Help. In this section I discuss each phase and sub-phase in the context of existing literature in the area.

### **Experience of Abuse**

Participants in my sample reported a range of abusive experiences which led them to enter the help-seeking model. These included sexual coercion, physical abuse, psychological abuse, controlling behaviours, legal-administrative abuse, abuse against their children, and verbal abuse. These abuse experiences are consistent with previous definitions and typologies of IPA (Johnson, 1995, 2006; Kelly & Johnson, 2008; Walker & Gavin, 2011). In this way, my participants' reports of these experiences further legitimize that men too experience IPA from female partners. Participants also described experiencing minor aggressive acts (e.g., pushing, shoving) occurring in the context of escalating arguments, which aligns with Kelly and Johnson's (2008) definition of SCV.

Participants further described various controlling tactics that were used against them. These included isolating the participant from their friends and family, denying the abuse and/or blaming the participant for the abuse, threatening to fight for full custody of a child, and threatening loss of access to that child if the participant ended the relationship. These experiences often occurred in the absence of violence and this was the most common type of abuse cited by participants. These descriptions align with the definition of IT, which: "includes multiple control tactics, of which the major categories are intimidation, emotional abuse, isolation, minimizing, denying and blaming, the use of children, male privilege, economic abuse, and coercion and threats" (Johnson, 2006, as cited in Nybergh et al., 2016, p. 5), and which often does not involve high levels of physical violence (Kelly & Johnson, 2008). Previous research suggests that IT is predominantly/exclusively perpetrated by men (Johnson, 1995, 2006; Johnson & Ferraro, 2000), thus my findings add to the literature negating this claim (Felson & Messner,

2000; Graham-Kevan & Archer, 2003; Hines et al., 2007; Hines & Douglas, 2018; Hines & Douglas, 2010a, 2010b, Laroche, 2005; Migliaccio, 2002; Nybergh et al., 2016; Straus, 2008).

My results also lend support for the recently emerging research area of forced and insisted sexual abuse (Próspero & Fawson, 2010), indicating that these too are abusive behaviours that men experience. Legal-administrative abuse (Tillbrook et al., 2010) has also more recently been identified a form of abuse, and includes a person using professional services in a manipulative and dishonest way, such as a woman filing a restraining order against a man who has experienced IPA from her, or claiming that IPA was perpetrated against her, but without substantial cause (Tillbrook et al., 2010). Participants in my study spoke of how their partners took advantage of their lack of knowledge of the legal system, for example in an effort to gain full custody of their children.

### ***Violent Resistance***

One participant reported that they too exhibited abusive behaviours in their relationship. As theorized by Johnson (2006), there are three ways that men can respond to abuse by their partner: non-violently, with violence but no controlling behaviors (i.e., VR), or with equal levels of violence and controlling behaviors as their female partners (MVC). The participant in my study described experiencing many months of abuse, where they did not fight back or engage in any mutually abusive behaviours. However, near the end of the relationship the participant described “smacking” his partner in response to her being physically aggressive with their child, alongside two additional incidents where he reported he was physical “back” to her. This participant described disappointment and frustration in himself following these behaviours.

Despite these behaviours aligning with purported definitions of self-defence and VR (Johnson, 2006) the participant reported that when he started engaging in these behaviours, their relationship transitioned from abusive to “toxic” (i.e., he used the term toxic to describe when both parties are engaging in abusive behaviours). Here, he no longer believed that he was being abused because he too was contributing to the problematic behaviour, albeit in response to her abuse. The participant’s description of the experience is interesting, as it provides insight into the responsibility that he placed upon himself for the behaviours, despite them being in response to already occurring abuse perpetuated by his partner. It also notes his changing definition of “being abused” – that men are no longer being abused if they are abusive in response. It is important to note that classifying behavior as VR does not excuse their aggression; rather, these

behaviours too are problematic, dysfunctional, and need to be addressed (Hines & Douglas, 2010b). Acknowledgement of this participants' language around the issue however, (i.e., taking responsibility, not referring to it as self-defence), provides important information surrounding the potential occurrence of VR in female-to-male IPA situations.

This discussion, though centered upon one individual case, sheds light on the potential limitations to self-reports of men's self-defence and VR, whereby society's expectations of men and men's expectations of themselves, might be limiting men's ability to describe their own actions as VR. This is particularly important, given claims that VR almost exclusively is exerted by women (Johnson, 1995, 2006; Johnson & Ferraro, 2000). First, it is possible that patriarchal assumptions of masculinity prevented the above-mentioned participant from viewing his behaviours as resistance. There is an ongoing narrative surrounding men's use of violence against women, whereby men are told "boys don't hit girls" from a young age (Wohlwend, 2007, p. 80). It is possible that this narrative has been internalized, and thus some men view their VR as a failure, and thus do not utilize the term self-defence to describe it. Previous research further indicates that in abusive situations, men are significantly less likely to be aware of the intention behind their behaviours (Barnett et al., 1997). However, no investigation has been done into men's perceptions of their use of violence or abuse as resistance or self-defence. This is a promising area for further inquiry.

### **Recognizing Severity of Abuse**

My results show that for men to continue through the help-seeking model, they had to recognize the severity of the abuse they experienced. This finding supports previous research about how failure to recognize the severity of abuse can hinder individuals' decisions to leave abusive relationships (Sita & Dear, 2020; Walker et al, 2019). My results further build upon this research, indicating that recognition of severity is also important for decisions to seek help, both during and after a relationship. Previous researchers have also shown that once distress reaches an unbearable level, men are prompted to seek help (Roddy, 2014).

In my sample, men exited the model when they did not recognize the IPA severity. Previous researchers have also noted that failure to recognize one's experience as IPA is a common component of men's abuse experiences (Sita & Dear, 2020) and can play a significant inhibitory role in their help-seeking journeys (Walker et al., 2019). More specifically, participants in previous research have reported that they felt like their experience was not

significant enough to make a report (Walker et al., 2019), which is precisely what was reported by the negative cases in Study 1. Furthermore, for participants who continued through the model, it often took numerous instances of abuse, many months, or even years for them to recognize the severity of their experience, and many spoke of the “straw that broke the camel’s back.” This too aligns with previous literature, whereby men have been found to report distress at their partner’s behaviour but will not label their partner’s actions as abusive until the patterns had been strongly established, or until after the relationship had ended (Sita & Dear, 2020).

### ***Justifying Partners’ Abusive Behaviours***

Men’s tendency to justify their partner’s abusive behaviour was often cited as a significant barrier for men in recognizing the severity of their experience. Justifications made by participants included blaming the abuse on the partner’s mental health (elucidated below), stress, believing it was just a phase, and/or excusing the partner’s behaviour as their own fault. This concept of justification has not been thoroughly investigated previously. There is one case study of an individual described the process of defining and redefining his values and beliefs to accommodate the abusive behaviours from his spouse (Nayback-Beebe & Yoder, 2012). He further described blaming himself for the abuse and making excuses for his spouse in an effort to continue to accommodate her behaviours into his values (Nayback-Beebe & Yoder, 2012). Eventually, this individual described a tipping point, when his spouse breached his values in an extreme way and he realized he had to leave the relationship (Nayback-Beebe & Yoder, 2012). This experience parallels many of the experiences of the men in my study, though their process of recognizing self-blame and excuses was both helpful for leaving the relationship, and for seeking help for it. Participants in my study also described an eventual tipping point, where they would recognize the excuses that they were making for their partner, and would either leave, and/or seek help for the abuse that they were experiencing.

Self-blame and providing justifications for a partner’s abusive behaviours can operate in a cyclical fashion, and both can be particularly salient barriers for men seeking help for the abuse. When men I interviewed made justifications for their partner’s behaviour, it often carried with it weight that they should have done something differently. This looked like explicit self-blame (e.g., I did not clean the dishes, it is my fault that she is acting this way), excuses which implied self-blame (e.g., she is stressed, I should have helped more), or pure excuses (e.g., she has an anxiety disorder, it is not her fault that she yelled at me). Self-blame and justifications

seem to imply the belief: “if the abuse is not her fault, or if it is actually my fault, then what is there to seek help for?” Thus, blame appears to be both internal and external for these men, which is not surprising given the epidemic of blame attributions and skepticism towards men who are abused by female partners (Bates, 2019; Hines et al., 2007; Zeinert, 2017).

A particularly prevalent justification that the men in this sample made for their partners was that their partner’s mental health was to blame for the IPA. This takes the onus off the partner themselves for the abusive behaviour and centers them as the one in need of help, possibly reducing the likelihood that the man will seek help for himself. Much of the literature about female perpetrators of IPA indicates that mental health is a common correlate with perpetrating IPA (Mackay et al., 2018; Magdol et al., 1997; Smith-Acuna et al., 2004). However, I was unable to find any research investigating how a partner’s mental health as a correlate to abuse might influence the abused partner’s perceptions of the abuse, and of seeking help. My research indicates that perceptions of the cause of abuse (e.g., mental illness), can play an important role in men acknowledging IPA severity, which in turn can prevent them from seeking help.

### **Social Support and Validation**

When men were met with support, and/or validation, this helped to facilitate their movement through the model. Participants noted that talking to friends provided a helpful way to organize their experience, which subsequently led them to Recognize Severity. Further, for my participants, talking to others also served as a way for others in the participants’ lives to reflect to the participant that the IPA was severe, which in turn helped participants to recognize its severity themselves. This is consistent with a number of previous studies on help-seeking for IPA (Barrett et al., 2020; Goodman et al., 1999; Mitchell & Hodson, 1983; Sheffield et al., 2004). Similarly, Brooks et al. (2017) found that men in their sample cited society as a crucial component of many aspects of their abuse experiences and spoke of a desire for a safe place for men to talk about their IPA experience. However, within this body of research it was unclear *how* social support acts as a facilitator. My results fill this gap, by depicting the importance of social support and validation from others to recognizing the severity of abuse, which in turn facilitates help-seeking.

### **Accessibility and Availability of Information and Assistance**

My results further highlight the importance of increasing both the availability and visibility of services for this population. Typically, if participants determined during Exploring

Options that there was no help available, they would exit the model. Notably, this determination of lack of help could be for two reasons: 1) there truly was no help available, or 2) there was help available, but the participant was not aware of it. Predominantly, when participants exited at this stage it was because they were unaware of the help that was available to them, rather than there truly being no help available.

This highlights the importance of increasing visibility of what services are available for men. This is consistent with the calls of previous researchers and men who experience IPA to increase awareness of already available services (Meyer, 2010; Tsui, 2014; World Health Organization, 2012). However, in general there are not enough services available to men for IPA concerns, and the services that are available are either deemed insufficient or not a good match for what they are wanting help with (Cheung et al., 2009; Shum-Pearce, 2016; Tillbrook et al., 2010; Tsui et al., 2010). Although my sample did not frequently identify this as a barrier, there was some discussion of being unaware that general services (e.g., psychologist, police officers), would be appropriate fits for their concerns. My results uphold previous calls to further develop additional, *specific* services for this population (Cheung et al., 2009; Shum-Pearce, 2016; Tillbrook et al., 2010; Tsui et al., 2010).

Furthermore, men's recognition of the severity of their abuse experience was further facilitated by hearing/viewing information about IPA from media resources (e.g., advertisements describing/defining IPA). For example, descriptions of abuse types and experiences were useful if participants encountered them, as they prompted them to reflect on whether or not their own experiences aligned with those described. This in turn helped them to recognize their experience as abusive (and consequently as something severe), if what they were experiencing was included in the abuse descriptions.

### **Coping on One's Own**

My results showed that men are likely to first attempt to cope with IPA on their own, before seeking help. The process of trying to cope on their own and realizing that this was ineffective served as a segue to them later seeking help. Similarly, in previous research men report that they prefer to deal with their own problems, as opposed to seek help from other people (Ellis et al., 2013). Cameron and colleagues (1993) suggest that those who ended up seeking help reported that they first tried to cope on their own but were not successful. These

results can have research and practical implications for appropriate development of support services for this population (see Chapter 9).

### **Initial Contact with Service Providers**

It is also important to note that I conceptualized men's initial encounters with counsellors and other service providers (e.g., talking to a police officer about the potential of charging a partner with assault), as men Exploring Options. With these initial contacts, the men had not yet obtained and engaged in help. Rather, they appeared to still be exploring their options by evaluating an initial appointment with a service provider. This evaluation process served as a method for participants to determine whether the help-provider and/or the service itself would be a good fit for their presenting concern. Participants in this study differed as per their engagement, with some engaging with the services that they sought, and others deciding not to return to, or engage further with those services. Similar figures can be found across literature where initial appointment nonattendance, as well as early dropout, are highlighted as perpetual problems within mental health services (Barrett et al., 2008; Hoare et al., 1996; Mitchell & Selmes, 2007). My results highlight how imperative first contact with a service provider can be and indicates that greater attention should be paid to these initial interactions with this population.

### **Previous Experiences with Help-seeking**

Previous negative help-seeking experiences arose as an important factor, particularly in Phase 4. Namely, when participants were deciding if a service would be helpful and beneficial to them, previous negative help-seeking experiences acted as a significant deterrent. Previous research has indicated that when men have negative experiences with seeking help, they often cite this as a reason for not seeking help in the future (Eckstein, 2009; Liang et al., 2005; Stephenson, 2009). However, my study is the first to discern exactly how negative help-seeking experiences operate as barriers to seeking help. Namely, negative, or unhelpful help-seeking experiences are considered during the subphases of Exploring Options and Weighing the Pros and Cons, and contribute significantly to Ambivalence, and are subsequently considered each time an individual seeks help for IPA. During this subphase men used these previous experiences as information regarding whether or not the options available to them were likely to be beneficial (i.e., will the pros outweigh the cons). Although these negative experiences could extrapolate to other forms of help, this typically was not the case with my participants. Thus, a negative experience with a police officer might make an individual determine that their services were

unlikely to be helpful in the future but would not necessarily be generalized to other forms of help, such as counsellors.

### **Common Pros and Cons of Seeking Help**

Previous research regarding help-seeking for a variety of presenting concerns has indicated the importance of weighing the pros and cons of help (Fisher et al., 1982; Kingsnorth & MacIntosh, 2004; Vogel et al., 2006). My results clearly corroborate these findings.

The predominant “pro” of seeking help for my participants pertained to the support and/or safety that they might receive because of seeking help. My finding that the perceived benefit of help facilitates help-seeking is supported by previous research (Rosenstock, 1974; Rughani et al., 2011). This benefit is also closely linked with Exploring Options, whereby if participants had explored their options and determined that help was available, suitable to their concern, and likely to be beneficial, then the weight of the “pros” during this sub-process was bolstered. As noted above, for some men, determining help as likely to be beneficial was influenced by an initial contact with a service provider. This finding is not surprising, given previous researchers emphasizing the importance of initial contact with service providers (Bruch, 1974; Macewan, 2008; Martin, 2000; McWilliams, 1999). For others, the perceived benefits of help were influenced by previous help-seeking experiences, or preconceived notions of help, similar to what has been found in previous research (Eckstein, 2009; Liang et al., 2005; Stephenson, 2009). These are important findings for the help-seeking process, as it is understood that if men believe they are likely to receive more benefit than harm from seeking help, then they will be more likely to seek out that help. This indicates that improving the helpfulness of services, as well as the *perceived* helpfulness of services is an important endeavour when working to encourage men’s help-seeking.

One salient “con” of seeking help was worries regarding the consequences that might befall the abusive partner. This concept also highlights the importance of recognizing the positive feelings that many individuals still hold towards an abusive intimate partner. It is not uncommon for individuals to hold romantic and loving feelings towards their abusive partner, and this can present as a barrier to them leaving the relationship (Pocock et al., 2020). Thus, similarly, it might present as an important barrier for individuals seeking help for abuse, particularly if they still hold romantic feelings for their partner, and thus do not want to see harm come to them. This finding has important implications for service providers working with this



population (See Chapter 9). An additional “con” of seeking help was the stigma that men feared might accompany help-seeking. Much of this fear of stigma was also wrapped up in participants’ fears of others’ perceptions of their masculinity (further described in Chapter 9). Fear of stigma as a barrier to help-seeking for men who have experienced IPA has been found consistently in previous literature (Overstreet & Quin, 2013; Vogel et al., 2006; Tsui et al., 2010; Walker et al., 2019).

Last, participants noted that money and time were significant “cons” of seeking help. Specifically, they often asked the question of whether help would be “worth” the time and money required of seeking it. This typically pertained to counselling services, as other help-providers do not regularly require payment. Previous researchers have identified finances as a relevant barrier to help-seeking for IPA (Lelaurain et al., 2017). The main point with this concept is that my participants were hesitant to invest time and money in a service that they were unsure would be beneficial. As such, this idea seems to be more clearly tied to ensuring that services are applicable and useful for men, rather than simply affordable. However, the converse is also important, as perhaps if services were not seen as such a financial risk, then more men might be willing to “take a chance” on seeking help that may or may not be beneficial. This highlights the need for subsidized mental health services and/or increased insurance coverage for individuals who might need help. In sum, men were far more likely to seek out help-services that: 1) would not result in consequences for their partner, 2) would not result in stigma towards the man, 3) would be worth the time and money, and 4) would be beneficial. These concepts should thus be strongly considered when developing intervention strategies for this population.

### **Ambivalence**

A common theme amongst sub-processes was Ambivalence. This concept is not considered a sub-process, but rather is conceptualized as the feeling that drove the men as they oscillated between Exploring their Options and Weighing the Pros and Cons. Ambivalence was ultimately what the men had to resolve to move past Phase 4 and on to Phase 5. Ambivalence is characterized in the psychological literature as: “simultaneously wanting and not wanting something or wanting both of two incompatible things. It has been human nature since the dawn of time” (Miller & Rollnick, 2012, p. 18). Ambivalence had been frequently noted in previous literature as a salient component of people’s help-seeking journeys (Englar-Carlson et al., 2005;

Good et al., 2005; Schauman et al., 2012), and studies have pointed to ambivalence as being linked to low motivation to seek help (e.g., Lee, 2009). My results echo these findings.

In my study, participants' feelings of Ambivalence were influenced by plethora of factors. First, participants spoke of an uncertainty regarding whether help would be beneficial for them. Within this, there were questions regarding if their situation was worthy of or appropriate for help, as well as questions of whether help would actually be worthwhile. Second, participants experienced Ambivalence influenced by societal masculine scripts (described in Chapter 9).

Furthermore, as noted above, at times men sought help but did not follow through to fully engage in this help. My results indicated that this failure to engage was often because an external influence had resolved the participants' Ambivalence (e.g., family pressure to seek help), rather than internal influences (e.g., internal motivation). This finding provides support for Self Determination Theory (Deci & Ryan, 1985), which posits that there are three basic types of motivation which influence behaviour: 1) intrinsically motivated behaviours (i.e., those which are performed voluntarily without external rewards or pressure), 2) extrinsically motivated behaviour (i.e., behaviours that are performed not for their own sake, but in order to receive a reward or to avoid some punishment), and 3) amotivation (i.e., behaviours that are engaged in without a clear understanding of their purpose). Within this theory, it is assumed that those behaviours which are influenced by intrinsic motivation and self-determination will be more likely to result in persistence, positive consequences, greater interest and increased life satisfaction (Pelletier et al., 1997). This pattern is evidenced in multiple studies, where the presence of both high-internal and low-external motivation is associated with the best outcomes, as found among those attempting weight loss (Williams et al., 1996), adherence to medication recommendations (Williams, et al., 1998), engagement in methadone maintenance treatment (Zeldman et al., 2004), and offenders' motivation to change (McMurran et al., 2006). My research confirms that external motivation is a less effective method of encouraging positive outcomes (i.e., engagement in help) than internal motivation, when extended to men who have experienced IPA.

However, this discussion is more complex for men who are fathers. These participants spoke of the importance of their children as external motivators for their help-seeking journeys (e.g., to keep them safe, to retain custody, to improve their mental health so they can care for their children better). Previous research does indicate that children are frequently cited as a

significantly motivator for people to seek help for IPA (Kelly, 2009; Petersen et al., 2004; Randell et al., 2011). Although less thoroughly investigated, other researchers have noted that men only sought help when IPA was harming someone other than themselves (e.g., children; Nayback-Beebe & Yoder, 2012). The concept of internal and external motivators for seeking help with this population appears to be multifaceted.

### ***Readiness to Change***

Readiness to Change was an additional contributing factor to moving from seeking help to *engaging* with help. This suggests that men might seek help while still experiencing Ambivalence. This information is relevant for service providers, as it suggests that readiness to engage in help-receiving, or follow through with services, is an integral part of help-seeking. This readiness to change/engage in services can be addressed by various service providers and is most frequently done via motivational interviewing, which “is a process that helps people resolve their Ambivalence and move toward healthy change” (Miller & Rollnick, 2012; p. 2; further expanded upon in Chapter 9).

### **Differentiating between Help-Seeking and Help-Receiving**

My results indicate that the concepts of deciding to seek help and receiving/engaging with that help are distinct. Making initial contact with a service provider does not mean that an individual is fully invested or engaged with that help. This differentiation between initial help-seeking and help-adherence and engagement has been found in previous literature. Henshaw and Freedman-Doan (2009) note that the factors associated with initiating treatment might be different than those which predict adhering and engaging with treatment. Thus, according to Henshaw and Freedman-Doan (2009), they should be clearly distinguished from one another. My findings provide further support for this differentiation, and for the distinctive factors involved in each.

### **Experiences Engaging with Help**

Notably, experiences with counsellors were predominantly (though not exclusively) described as positive. On the converse, experiences with police, the legal system, and social workers were predominantly described as either unhelpful or actively harmful. This finding aligns with previous literature (Brogden & Nijhar, 2004; Cook, 2009; Douglas & Hines, 2011; Stephenson, 2009). It is important to note that this difference in men’s experiences with various service providers can be due to a plethora of reasons. For one, counsellors are typically trained,

and are ethically called to discern who their client is and prioritize the client's well-being in particular. For example, ethical standards such as those provided by the Canadian Psychological Association (CPA, 2019), indicate that the client's wellbeing be considered first and foremost, and is typically considered of higher importance than that of the community's wellbeing. However, areas such as social work and the police force are typically tasked with ensuring the safety of the entire family system and/or community (Charman, 2018; Laird et al., 2017). As such, a potential explanation for this discrepancy between service experiences might be due to differences in who the service provider deems to be their client. This finding also makes sense, given the finding that men's experiences with social worker in a counselling role were typically positive, whereas experiences with social workers in a child-protection role were typically negative.

### **Comparison to Previous Theoretical Literature**

In line with Charmaz's (2014) recommendation for grounded theory, I delayed review of the pertinent theoretical literature until after my theory had been fully formulated. This allowed me to ground my theory in my data, and to attempt to be unbiased by preconceived notions of what should be involved in the help-seeking process. In this section I compare and contrast my theory with previous help-seeking theories. There is a plethora of theories regarding the help-seeking process (for a full description of these theories, please see Chapter 1). See Table 5.1 for a visual depiction of the comparisons and contrasts between my model and those previously posited.

### ***Health Belief Model***

Within the Health Belief Model (Rosenstock, 1974), help-seeking behaviours can be understood through the help-seeker's experience/understanding of severity, perceived benefits of help, barriers to help, and self-efficacy towards making change (as cited in Henshaw & Freedman-Doan, 2009). The importance of these four areas was reflected in my results. The idea that help-seeking behaviours can be facilitated by realizing the severity of one's situation (Goldsmith et al., 1988; Henshaw & Freedman-Doan, 2009), aligns with my phase of Recognizing Severity. My subphase of Exploring Options corroborates Henshaw & Freedman-Doan's (2009) model, whereby they noted that the perceived benefit of help was a facilitator for help-seeking. Further, Weighing Pros and Cons is noted in both my model and the Health Belief

Model. However, self-efficacy as component of help-seeking was not discussed by my participants.

Goldsmith et al.'s (1988) reformulation of this model adds further clarity and context to help-seeking journeys. Their addition of stages to the model aligns with my findings that men's help-seeking is a phase-based process. Furthermore, their recognition of the different variables that might be pertinent at each phase (e.g., gender, help-seeking desirability, availability of services), is consistent with my results as well. Factors such as masculinity, preconceived notions of help-seeking, and definitions of problem as worthy of help all played important roles at different stages of the help-seeking process.

### ***Theory of Planned Behaviour***

The Theory of Planned Behaviour identifies intentions and feelings of control over one's behaviour as predominant factors in undertaking a given behaviour (Ajzen, 1991). My results are consistent with this theory. Namely, my sub-phase of Weighing Pros and Cons aligns with Ajzen's (1991) mention of subjective norms, whereby individuals weigh the rewards and/or consequences of engaging in a behaviour. Further, Ajzen's (1991) concept of perceived behavioural control aligns with my sub-phase of Exploring Options. Men noted that they were more likely to see help when they were readily aware of the services available to them, and when these services were readily accessible. Smith et al. (2008) further found that within the Theory of Planned Behaviour, subjective masculinity norms and attitudes towards help-seeking significantly influenced men's help-seeking behaviours. Similarly, my results show that masculinity norms play a significant role in influencing men's decisions at each stage of the help-seeking process.

### ***Network Episode Model***

Pescosolido's (1992; 1998) Network Episode Model emphasizes the importance of social influences on how, when, and if individuals receive help. My results are again consistent with this theory; social support arose as a salient factor at nearly every stage of the model. As previously noted, support and validation from others helped men recognize the severity of the abuse that they were experiencing, helped men become aware of available services, provided recommendations for services that men trusted, and helped men to overcome Ambivalence about seeking help. Furthermore, Pescosolido (1992) notes the importance of differentiating between those who were coerced, and those who sought help voluntarily. My study results also reflect

this, as participants who sought help because they were coerced, or strongly encouraged, were more likely to disengage from the help they sought. Pescosolido (1992) further posits that help-seeking is a process involving a series of decisions, rather than a single planned choice, which is further corroborated by the phase-based nature of my findings.

### ***Information Processing Model***

Components of the Information Processing Model (Vogel et al., 2006) are also supported by my results. In the second step of Vogel's (2006) model, individuals must decide if there is a problem that needs to be addressed and determine if there is something that can be done about this distress. This step appears to combine Phase 2 and Phase 4 of my model, whereby participants must Recognize Severity of the problem, and then Explore Options to determine if they were appropriate for their presenting concerns. Within this second step, Vogel et al. (2006) notes that an individual may not consider formal services for a variety of reasons, such as limited knowledge about the effectiveness of therapy, the types of professional resources available or what would happen if they sought treatment. Similarly, in my study, participants exited the model for reasons such as being unaware of help-options, believing that help would not be useful, and concerns of the consequences that might arise from seeking help.

In the third step of the Information Processing Model, individuals evaluate the pros and cons and identify options, and these are conceptualized as one sub-phase (i.e., Exploring Options). Similarly, in my model participants had to Weigh the Pros and Cons of their options and Explored those Options. However, my participants oscillated between these two phases, and thus I conceptualized and labelled them as separate processes. Thus, my results provided a greater in-depth and nuanced understanding of the experiences of Exploring Options and Weighing Pros and Cons.

Last, Step 4 of Vogel et al.'s (2006) involves individuals evaluating and considering the outcomes of their behaviours. These evaluations then lead to new decisions about what to do next (Vogel et al., 2006). Similarly, my results showed that evaluation of previous help-seeking experience as negative plays an integral role in the next time that individuals consider seeking help. These negative experiences were factored into Phase 4 of Deciding to Seek Help, where men are tasked again with Weighing the Pros and Cons and determining if help is going to be beneficial. If they have had previous negative experiences, then they will be much more likely to

determine that the cons outweigh the pros and/or that help will not likely be beneficial for their presenting concern.

Vogel (2006) also suggested that individuals tend not to choose professional services (e.g., mental health services), as a first choice but rather after other sources of help have been attempted. Thus, seeking help from professionals might only occur after other sources of help have failed (Vogel et al., 2006). However, within my study this experience is described by my participants as more nuanced. My results show that the act of evaluating the outcome of seeking professional help occurs after Phase 5 (i.e., Obtaining and Engaging in Help). However, the act of evaluating the outcome of other forms of help (e.g., friends, self-help), occurs during Phase 3 (i.e., Realizing Limitations). Here, participants tried to cope with the abuse “on their own,” either individually, or by seeking the support of friends or other informal sources of help (e.g., Internet). If men then evaluated these sources as not providing sufficient help, they then realized that they were limited in their ability to help themselves, or gain help from their immediate surroundings, and then would progress to the next phase. This is an important distinction, as there appears to be a difference in the processes of professional vs. informal help-seeking (as was investigated through the Information Processing Model).

### ***Learned Helplessness and Survivor Models***

Walker (1979) suggests that help-seeking efforts will decrease as the severity of violence increases, and helplessness becomes more pronounced. Although this theory was already previously challenged (Bowker, 1983; Pagelow, 1981), my results further contradict this supposition, whereby a recognition of the severity of abuse was found to *facilitate* help-seeking behaviours. As such my findings uphold the Survivor Model (Gondolf & Fisher, 1988), which predicts that worsening abuse is related to an increase in help-seeking efforts.

### ***Barriers Model***

Furthermore, the Barriers Model has been put forth as an effort to incorporate individual and structural-level factors into understandings of help-seeking (Burgess-Proctor, 2012). Namely, barriers due to environmental, family, socialization and role expectations, psychological consequences of violence, and childhood abuse/neglect have been put forth as important components throughout help-seeking journeys (Grigsby & Hartman, 1997). My results clearly support the calls of Grigsby and Hartman (1997) to include individual and structural level

factors, as lack of accessible services, family support, masculinity and role expectations, and low self-esteem from abuse all presented as influential throughout men's help-seeking journeys.

### ***Behavioural Model of Health Care Utilization***

Andersen (1995) presented this model as an explanatory model for help-seeking for IPA. This model conceptualizes predictors of help-seeking into three categories: predisposing characteristics, enabling resources, and needs-based factors. All three components of this model are supported by my study. My results suggest that predisposing characteristics, such as traditional gender role adherence, play an important role in seeking help for IPA. Furthermore, enabling resources, such as awareness and accessibility of resources, facilitated men's help-seeking in my sample. Last, needs-based factors were identified in Phase 2, whereby symptom severity/recognition of severity of symptoms, were necessary in order for men to progress through the model.

### ***Rational Choice Model***

Kingsnorth and MacIntosh's (2004) claim that decisions to seek help are based on complex processes whereby costs and benefits of involving criminal justice personnel in their lives, is supported by this research. The results of my study indicate that men go through a sub-phase of Weighing the Pros and Cons of seeking help, prior to Deciding to Seek Help. My results extend this model to including all types of help sought, not solely that of the criminal justice system. Further, through my model I found that these pros and cons will differ, according to the type of help sought, their relationship with their partner, and their internalization of societal scripts.

### ***Cognitive Process Model***

Liang et al.'s (2005) Cognitive Process Model is said to be the most comprehensive attempt to theorize about women's help-seeking for IPA (Burgess-Proctor, 2012). Thus, this model will be discussed here more thoroughly, and will be revisited again in the General Discussion. This model proposed that help-seeking occurs in three stages (described in Chapter 1). This model aligns with many components of my model. Namely, stage 1 aligns with Phase 3 of my model, whereby participants needed to recognize the severity of their situation in order to seek help. Stage 2 and 3 of Liang et al.'s (2005) model align with Phase 4 of my model, whereby participants reviewed their options which assisted in them Deciding to Seek Help. Liang and colleagues (2005) also conceptualize help-seeking as a reciprocal, multi-layered, multi-staged



process that is shaped by individual, interpersonal, and sociocultural factors, which aligns with my own findings that interpersonal and sociocultural factors are influential at every stage of the help-seeking process.

Despite these similarities, the Cognitive Process Model is lacking in complexity, namely regarding the more specific nuances that occur throughout its three proposed stages. The model developed through my study provides clarity regarding these gaps and allows for the complexity of the help-seeking process to be fully appreciated. Specifically, my model adds an additional phase which follows one's recognition of severity. This is an important addition, as there are cases where individuals who experience abuse will recognize the severity and problematic nature of their abuse but will not decide to, or need to, seek help. Thus, my discovery of Phase 3, Realizing Limitations, helps us to better understand why some people seek help, while others do not, despite recognizing the detrimental nature of their relationship. Furthermore, my results contradict Liang et al.'s (2005) postulation that deciding to seek help is followed by determining what help is appropriate. Rather, my model shows that evaluating and determining sources of help is one component of the broader Deciding to Seek Help. Not only do men review the options available to them, they weigh the pros and cons of these various options and investigate whether these options are likely to be appropriate and beneficial to them. As such, my model provides a much more in-depth analysis of Deciding to Seek Help. Last, my results suggest that the help-seeking process does not cease once an individual has determined the appropriate source of help. Rather, help-seeking, and help-receiving arose as distinct concepts, where seeking help does not necessarily mean that the individual will engage or remain engaged in the help that they sought.

### ***Feminist Pathways Theoretical Model***

This model (Burgess-Proctor, 2012) brings a trauma-informed lens to the process of help-seeking. Burgess-Proctor (2012) suggests that help-seeking should be considered a trajectory of behavior. Specifically, women's inclinations to use or avoid certain help-seeking strategies are shaped by their childhood traumatic experiences. Previous trauma histories were not investigated fully in my research project. However, discussions did arise regarding previous traumatic experiences, and previous help-seeking for these traumatic experiences. Namely, previous positive experiences with seeking help for ostensibly unrelated traumatic events, greatly influenced participants' future willingness to seek help. It appeared as though these participants

built an identity of “help-seekers,” whereby they had learned that help is available and beneficial, and likely would continue to be for future traumatic events. These results are tentative, as they are based on a small subset of the recruited participants. Therefore, help-seeking as a trajectory of behaviour, and the concept of help-seeking as a component of one’s identity, should be investigated in future research.

### ***Intimate Partner Stigmatization Model***

This model’s emphasis on stigmatization as a barrier to help-seeking (Overstreet & Quinn (2013) is strongly corroborated by my results. Cultural stigma presented in my model via the societal beliefs surrounding the rarity and mildness of men’s IPA experience. These societal beliefs have resulted in a dearth of specific services for this population, as many individuals do not believe IPA perpetrated against men to be a significant issue (Bates et al., 2019; Finnegan et al., 2018; Russell, 2018). Stigma internalization was present in my sample as well, namely during the experience of Recognizing Severity and Realizing Limitations. My participants spoke of many instances where they believed that they should be able to handle the abuse on their own, and where they minimized their experiences. It is plausible that these thoughts are results of internalization of the stigmatizing attitudes that broader society holds towards this populations. Last, anticipated stigma was evident in during the subphase of weighing pros and cons. My participants reported that a salient con of seeking help was the anticipation of stigma from friends, family, service providers, and the broader community. As such, all aspects of the Stigmatization Model were supported by my Study 1 results.

### ***Summary***

My detailed review of the previous theoretical literature in Chapter 1 depicts disjointed and/or surface level hypotheses regarding the process of help-seeking. Many of these theories postulate that there are important predictors and/or facilitators of help-seeking but neglect to develop a comprehensive model which ties these predictors together. A small subset of these theories provides an organized step-based model of help-seeking but are lacking in their complexity. This complexity can only be found by speaking with those who are actually seeking out the help. My model fills this gap through developing an inductive theory that is grounded in the stories of men who have experienced IPA. My model provides insight regarding both predictors/facilitators of help, and the specific, in-depth steps that comprise that help-seeking journey. Furthermore, as noted in Chapter 1, it was unknown whether previous theories of help-

seeking for IPA would be applicable to men. I have further filled that gap in the literature by providing a model of help-seeking based on, and developed for, men who have experienced IPA.

### **Social Determinants of Health**

It is important to recognize the context that men operate within when they seek help for IPA. Previous theories have been critiqued for not incorporating individual and societal-level factors into their model. However, in my model, social determinants of health (SDH) are evident, and I believe it is important to acknowledge and discuss these in order to recognize the multifaceted, idiographic nature of individuals' IPA experiences.

SDH are “the circumstances in which people live—i.e. the economic, political, social, environmental, and cultural conditions that affect the health of these individuals” (Viner et al., 2012, pg. 1642). The World Health Organization (2008) describes SDH as the conditions or circumstances that are shaped by communities and families, as well as by the distribution of power, money, and various resources at global, national, and local levels. SDH are further affected by policy decisions at each of these levels (World Health Organization, 2008). According to the World Health Organization (2008) there are six main SDH: 1) economic stability (e.g., employment, expenses, income), 2) neighbourhood and physical environment (e.g., housing, walkability, safety), 3) education (e.g., language, literacy, early childhood education), 4) food (e.g., hunger, access to healthy options), 5) community and social context (e.g., social integration, support systems, stress), and 6) health care systems (e.g., health coverage, provider cultural and linguistic competency, provider availability). A visual depiction of the SDH alongside my model can be found in Figure 5.

### ***Economic Stability***

Economic stability stands out as something that I speculate would be particularly relevant during Phase 4 of the model. As noted by my participants, when evaluating pros and cons, the cost of services presented as a salient con. This is unlikely to be as salient of a concern for others who are more financially secure. Further, I speculate that economic situations could influence the types of help sought by individuals within the model. For those who are of lower socio-economic status, it is more likely that housing and shelter will be a more salient need, as opposed to those who have a higher income and are able to obtain their own housing after leaving an abusive relationship.

### ***Neighbourhood and Physical Environment***

With regards to neighbourhood and physical environment, I speculate that accessibility of services (i.e., as described in Phase 4, sub-phase of Exploring Options) might be influenced by aspects such as walkability and/or proximity to an individual. For example, if there are no services in their immediate vicinity, and/or if they do not have access to transportation to obtain those services, then it much less likely that they will proceed through the model. This was discussed by my participants, whereby one noted that they did not realize that there were services available for their concerns until they entered university, where these services were widely advertised.

### ***Education***

Additionally, education can play an important role at many stages of the help-seeking process. If individuals do not have knowledge of the occurrence of IPA and/or of what a healthy relationship looks like, it is likely that they will encounter more difficulties with Recognizing Severity. Furthermore, education pertaining to mental health and/or support services available to individuals can play an integral role in Phase 4, where individuals are tasked with exploring the options available to them. This sub-phase will thus presumably be more easily overcome if individuals have previously been made aware of the services that are available to them.

### ***Food***

Food, the fourth component of the SDH, will likely further play a role in the help-seeking process, namely in ways outlined by Maslow's (1943) hierarchy of needs. Specifically, I speculate that if more basic needs such as food are not met, then it is unlikely that individuals will seek help for higher-order needs, such as mental health.

### ***Community and Social Context***

Community and social context have been discussed amply above, as participants in my study consistently mentioned the importance of social support on their help-seeking journey. This support played a role at nearly every phase of my help-seeking model, through validating men's experiences, encouraging them to seek help, and providing them with ideas of options for seeking help. Thus, it is important to recognize that variability in levels of social support will likely influence men's ability to progress through this help-seeking model. This aspect of the SDH also presented as important in my study, by way of the types of communities that they associate with. For example, one participant spoke of having a group of friends who frequently

minimized their female partners' abusive behaviours and viewed them in a humorous light. This communal attitude towards abusive behaviours then played a role in influencing this participant's ability to recognize the severity of the abuse that he was experiencing. Similarly, this group of friends valued traditional masculinity and "toughing it out," and thus one participant received the message from them that seeking help for the abuse would lead to ridicule, thereby presenting a barrier for him to seek help.

### ***Health-Care System***

The health-care system also has an integral influence on men's help-seeking journeys. First, as discussed in the context of economics, if men do not have access to health care coverage (both mental and physical coverage), this will present as a significant barrier for them, and can be conceptualized as a con in the sub-phase of Weighing Pros and Cons. Those with health-care coverage are thus much less likely to consider the cost of services as a con preventing them from seeking help. This arose in my study when participants discussed the cost-related barriers to seeking help. Second, provider availability and accessibility will play a significant role, again in Phase 4 of this model. If individuals seek options and discover that there are none, or if the options available to them hold significant wait times, then this will likely act as a trigger to exit my help-seeking model. This too was reported by participants in Study 1. It is also important to note that this accessibility and availability of services will presumably be influenced by the location where someone lives, as well as their socioeconomic status (SES; e.g., private services are typically more accessible, but will cost more than public services). A final component of health-care coverage is the cultural and linguistic competency of providers. Although not mentioned by my participants, we know that White, English-speaking service providers are the norm in Canada, and thus individuals with linguistic and cultural backgrounds which are diverse are often limited in their service options. I speculate that this issue, again presented in Phase 4 of Exploring Options, would present as a salient barrier, particularly if help-seekers do not speak English, and/or would derive more benefits and/or comfort from a service provider who understands their cultural background.

## **Culture**

IPA and help-seeking and receiving for that abuse can be interpreted, felt, understood, and attended to in idiosyncratic ways, according to the cultural context within which they occur. As noted in Chapter 2, culture extends far beyond outdated conceptualizations of race and ethnicity. Rather, there are multiplicities of culture. Groups of people of (but not limited to) various ethnicities, language backgrounds, institutions, workplaces, living spaces, religions, and genders can all hold different values, attitudes, and practices. With this in mind, my model was developed within a Western context, and utilizes a very Westernized, euro-centric perspective of help and the components within it.

### ***Religion and Cultural Heritage***

Individuals' religious background, cultural heritage, and ethnic background can all act as significant influences on help-seeking journeys. For example, there are some religious and/or cultural groups where a level of physical violence in relationships is normalized or accepted (Tse, 2007). Thus, cultural location might affect individuals' ability to recognize the severity of the abuse that they are experiencing. Further, the emotions which I found to be salient during help-seeking for IPA can differ per cultural locations. For example, although shame is a universal human emotion, appearing in all known human cultures (Brown, 1991; Darwin, 1872; Fessler, 1999; Tracy & Matsumoto, 2008), the experience of shame, and the reasons behind feelings of shame, differ cross-culturally (Bear et al., 2009; Sznycer et al., 2012; Wallbott & Scherer, 1995). Additionally, a significant part of my model, namely the concept of Ambivalence, is also experienced differently by different cultures (Heine & Lehman, 1997; Steenbergen & Brewer, 2004).

In addition, the type of services identified as options and/or suitable options, will be influenced by ethnic, religious, and cultural backgrounds. As noted above, for those individuals who are new to Canada, there might not be service providers who speak their language, or who are familiar with their religious background. Previous narrative and meta-analytic reviews show that across studies, people of color tend to prefer therapists of their own race/ethnicity (Cabral & Smith, 2011; Maramba & Nagayama Hall, 2002; Shin et al., 2005). Further, there is ample evidence for the importance of multicultural competence in relation to therapeutic outcomes (Owen et al., 2011; Worthington et al., 2007). Given the dearth of counsellors who identify as diverse (APA, 2018), and/or who are trained to be multiculturally competent (van Gorp et al.,

2000), it is likely that minority clients will have a different experience with services, compared to those who identify with the dominant culture. In addition, the types of options surveyed will likely differ per cultures of individualistic and collectivist backgrounds. For example, the Western tradition of seeking help from a stranger such as a psychologist may be considered culturally inappropriate from a collectivistic perspective, as: “the behaviors, emotions, thoughts, and motivations of interdependent selves are seen as closely embedded with important others (Erez & Earley, 1993; Yeh & Wang, 2000)” (as cited in Yeh et al., 2006, p. 136).

The pros and cons identified in the second sub-phase will also likely differ according to individuals’ cultural locations. For example, typically, threats to own or others’ perceptions of masculinity was indicated as a con to seeking help. However, the intensity and understanding of this threat to masculinity will differ per cultural locations, as masculinity is understood and enacted differently cross-culturally (Tan et al., 2013). For example, one participant discussed having grown up in a country where traditional masculinity was valued, and seeking help was viewed as exemplary of weakness. He reported that this cultural background shaped his help-seeking journey, as he believed that this traditional view of masculinity was toxic and wanted to seek help as an act of fighting against his upbringing. Further, the consequences of non-adherence to traditional masculinity will differ per the cultural context, with research suggesting that they can range from acceptance (Mahalingam, 2003), to mocking (Hines et al., 2007), to various forms of punishment (De Moya, 2004).

### ***Personal Histories/Abilities***

Personal histories and abilities might also influence the help-seeking trajectory. For one, previous experiences with trauma might be conceptualized as a “culture” or a collective experience, one which is understood as having common experiences and outcomes. Briere (2002) found that individuals who have experienced trauma can develop narratives of initial and subsequent traumatic events as experiences that are normal and/or deserved, suggesting that these individuals might have more difficulty recognizing the severity of their abusive relationship. Conversely, when multiple traumas accumulate over time, they may be associated with more severe and complex psychological reactions (Banyard et al., 2001; Kessler, 2000; Follette, et al., 1996; Kubiak, 2005; Van der Kolk et al., 2005). As a result, these individuals might be more adept, or quick to recognize severity, due to their increased vulnerability to psychological distress.

Other cultural locations, such as ability status (e.g., chronic mental or physical illness, being a wheelchair user), might also influence someone's experience of Realizing Limitations. For example, an able-bodied individual might not be limited in their ability to quickly flee an emergent abuse situation, whereas an individual who utilizes a wheelchair might require the help of a service provider to safely and quickly leave the situation. Additionally, an individual with a chronic mental illness might have a different threshold for seeking help for depressive or trauma-related symptoms, compared to an individual who has never experienced mental health concerns.

### ***2SLGBTQ+ Community***

The 2SLGBTQ+ community has also been previously conceptualized as a cultural group (Parmenter et al., 2020). In this way, identification with the 2SLGBTQ+ community might influence individuals' experience of the help-seeking journey. Notably, I recruited participants who were in abusive relationships with women. As I discussed in Chapter 1, I wanted to focus on men who were seeking help for female-perpetrated IPA, given the importance nuances of intersectionality that would be missed if I combined all sub-populations of men who experience IPA into one sample. As such, it is important to note that the journey through my model will very likely differ if a person identified with the 2SLGBTQ+ community. For example, there is a dearth of services specifically tailored for the 2SLGBTQ+ community (Ford et al., 2013; McCann & Sharek, 2016), which will likely play a role in these individuals' experiences of Exploring Options. Furthermore, research suggests that individuals from the 2SLGBTQ+ community experience stigmatization from service providers (Brown & Groscup, 2009; Renzetti, 1989; Shipway, 2004), which would influence their experience of Phase 5, and subsequently any re-entry into the help-seeking model. Phase 1, Experiencing Abuse/Distress could also be differentially experienced, given the higher rates of IPA in the 2SLGBTQ+ community (Bartholomew et al., 2008; Chesley et al., 1998; Messinger, 2011; Nowinski & Bowen, 2012).

### ***Gender***

My results further suggest that there might be some gender differences in the help-seeking journey, namely that men might require help for IPA for different reasons than women. My participants did not report seeking help for physically leaving the relationship (e.g., requiring resources or safety concerns). Furthermore, many men in my sample reported feeling confident that they could cope with the physical violence of their partners. This is echoed in previous research, where men typically report that the non-physical abuse is more prevalent, and



deleterious, than the physical abuse (Bates, 2019; Nybergh et al., 2016). Previous literature also indicates that it is not often difficult for men to leave their relationships because they have the financial resources to leave (Goldin & Mitchell, 2017; Pagelow, 1985; Saunders, 1988; Statistics Canada, 2019; Vitali & Arpino, 2016), and that safety and/or fear do not typically present as barriers to leaving and/or reasons for accessing help (Durfee, 2011; Sita & Dear, 2020). This is different than what is seen in the female IPA literature, where typically noted barriers, or limitations to seeking help include safety concerns when leaving the relationship (Fanslow & Robinson, 2010), and lack of financial independence (Sanders, 2014). This is not to say that men cannot experience financial constraints or safety concerns when leaving the relationship, as previous research has identified that men can experience significant fear and safety concerns (Brooks et al., 2017; Sita & Dear, 2020; Tillbrook et al., 2010) as well as financial barriers to leaving the relationship (Hines & Douglas, 2010). However, this finding does suggest that safety/financial constraints might not be the foremost or most common reason for which men seek help.

More commonly in my sample, individuals sought help for the *decision* to leave the relationship, among other reasons such as mental health and children's safety. This is an important finding, as it highlights the potential qualitatively different reasons why women and men might seek help for IPA and might further elucidate a difference in the limitations that they face. These discrepancies point to a need to explicate precisely what men want and need help for. This call has previously been made by Sita and Dear (2020) who noted that although participants in their study were physically abused and reported fear of future abuse, there was no report of fear that they might be physically injured to the point of death. As such, they stated that if this experience is common, then the service needs for men who experience IPA might be different than those of women (e.g., might need to focus more on providing logistical support for leaving the relationship rather than emergency services). As such, if housing and physical safety continue to be non-significant concerns or are not recognized as areas where men are limited in their abilities to cope (e.g., as in this current study), then perhaps help-providing efforts should be focused elsewhere. Further research is needed to understand where men believe their coping limitations lie, and what service might best be developed to meet these needs.

## CHAPTER 6: STUDY 2 METHODS

The behaviours and responses of service providers when working with men who have experienced IPA can have an indelible influence on these men. As discussed, several studies indicate that service providers might be biased and/or prejudiced in their responses towards men who experience IPA (Follingstad et al., 2004; Hamilton & Worthen, 2011). However, results have been mixed, and research specifically with counsellors who work with men who experience IPA shows that they report holding supportive attitudes towards them (Hogan et al., 2012; Molloy, 2017; Valgardson, 2014). Overall, limited research has investigated theoretical underpinnings of the journey to become someone who provides help to men who experience IPA. Based on the research base depicting that a number of counsellors support this population and their communicated desire to see competent work done with them (e.g., Roddy & Gabriel, 2019), this study specifically investigated the process that counsellors go through to become someone who provides therapy to men who experience IPA. It is important to further investigate this subset of service providers in order to clarify the process through which they come to develop their perceptions of men who experience IPA, how and if these perceptions change as they continue to work with men who experience IPA, and how these perceptions and experiences might influence the types and quality of therapy that they provide.

Therefore, in Study 2 I utilized a bottom-up approach (i.e., grounded theory) to develop a theory of the process of becoming a counsellor who provides therapy<sup>10</sup> to men who had experienced IPA from a female partner. This study expanded on previous research into service providers' and counsellors' perceptions of and attitudes towards men who experience IPA, recommendations for competent counselling practice with those who experience IPA and theoretical research into professional identity development and working with stigmatized populations. Through this study I developed a theory in efforts to consolidate these various research areas and provide an understanding of the process by which counsellors come to hold certain perceptions of stigmatized populations (i.e., men who experience IPA), decide if they want to provide assistance to men who have experienced IPA, and how/if they competently implement this assistance.

By developing a more nuanced understanding of how counsellors come to perceive and respond to men who experience IPA, we can better work towards ameliorating the negative

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<sup>10</sup> The terms counselling and therapy are used interchangeably throughout this document

responses that men so frequently receive when they seek help. A number of factors likely contribute to this process (e.g., experience working with men who experience IPA, perceptions of traditional gender roles). However, this topic was explored in a non-directive manner. Participants were allowed to tell their stories as they saw fit and were encouraged to speak about what facets of their lives have influenced their perceptions of men who experience IPA, and what they view as important factors in how they choose to respond to men who experience IPA.

## **Procedure**

I obtained approval from the U of S Research Ethics Board (REB) to conduct my research study. As per theoretical sampling, I submitted amendments to the REB as needed. I provided all participants with a copy of the consent form prior to the interview (see Appendix B.2 & B.2.1). All participants provided verbal informed consent and this was documented on a hard copy of a consent form by me. All interviews were audio-recorded. On average, initial interviews lasted 60 minutes (*range* = 39 to 92 minutes). Follow-up interviews lasted approximately 49 minutes (*range* = 39 to 58 minutes). At the end of the initial interviews, I asked participants demographic questions to describe my overall sample. Participants were then debriefed and provided a debriefing form (see Appendix B.5), and were thanked for their time. All participants consented to be contacted for future interviews if needed.

## **Recruitment**

Recruitment was aimed at individuals who were over 18 years of age, who currently or have previously provided counselling services to man who experienced IPA, and who resided in North America. I recruited participants through a variety of outlets. First, I utilized social media, posting recruitment materials on our research lab's Facebook page as well as my own and allowed others to share the materials on their own Facebook page. I also contacted various counselling locations via Facebook and asked permission to post the recruitment materials on their Facebook pages. I further contacted various locations across Saskatchewan where service providers might be employed. I sent emails to the administrators at these locations, and included recruitment materials in these emails, which had our lab's telephone number and email address. I asked these administrators to email these materials to their staff. Furthermore, my supervisor and a colleague both sent out my recruitment materials to listservs that they are members of, which they believed might include individuals who would meet my study criteria. Additionally, I posted the recruitment materials for this study on PAWS, which is a website for students, staff,

faculty, alumni, and other members of the University of Saskatchewan community.

However, these methods did not recruit a large enough sample, and theoretical sampling further indicated that I needed to recruit individuals who did more specialized work with men who experience IPA. Thus, I developed a list of counsellors and service provision centers across North America, who provided specialized counselling services to men who have been in abusive relationships. I then contacted these individuals and agencies and provided them with my recruitment materials and information about the study. The same process was utilized to recruit participants who were considered negative cases. To inquire and/or sign up for the study, potential participants could send an email to a secure, U of S email account, or contact our lab telephone. Participants were contacted by telephone in the VideoTherapy Analysis Lab (ViTAL) in the Arts building at the University of Saskatchewan.

### **Participants**

In total, 14 individuals responded to my various recruitment materials to indicate interest in my study. Six individuals did not respond to contact necessary to schedule interviews. Eight of these individuals maintained contact and agreed to participate in the study. The final sample consisted of six individuals who had provided therapy to men who have experienced IPA, and two negative cases<sup>11</sup> who provided therapy to different stigmatized populations (i.e., therapy with individuals in the 2SLGBTQ+ community, and with individuals who have committed sexual offenses). In total, I conducted eight initial interviews and three follow-up interviews. In order to ensure maximum confidentiality, and given the size of the community where local participants were recruited, demographic information for age and ethnicity is removed (Allen & Wiles, 2016). Participants' educational backgrounds included Bachelor of Social Work, Master of Social Work, Ph.D. in Clinical Psychology, and a Post-Graduate Diploma in School Counselling. All participants were currently employed in positions where they provided counselling to individuals. Of the participants who provided therapy to men who experienced IPA, three specialized in the area of IPA and men's IPA, while three encountered this population inadvertently through the nature of their practice. Years of practice ranged from 1.5 to 39.

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<sup>11</sup> Participants not meeting specific inclusion criteria or who are different from the remainder of the sample, and which allow researchers to assess the boundaries of developed categories and confirm hypotheses regarding the process service providers go through to provide help to men who experience IPA (Booth et al., 2013; ton & Miller, 2000).

## **Transcription**

Interviews were transcribed by either myself or a trained research assistant who had signed a confidentiality agreement. Interviews were transcribed to include gerunds, pauses, and emotional content. These transcripts were deidentified and saved in a Word document on a password-protected computer, on a secure lab drive. From there, transcripts were printed into hardcopies, and stored in a binder, which was kept behind three locked doors.

## **Data Generation**

All participants were contacted for interviews on a secure telephone in the aforementioned lab space. The original plan was to have participants participate in an initial screening interview (Appendix B.1). However, screening questions were often answered by the participants' initial contact email regarding their interest in the study (i.e., email signature indicated profession, and initial contact email indicated experience with men who have been in abusive relationship). As such, screening interviews were not typically conducted with participants. In total I conducted nine initial interviews (two which were negative cases) and three follow-up interviews.

In alignment with grounded theory methodology, the data was generated in multiple phases. Phase 1 consisted of conducting interviews with three participants who had provided therapy to men who have experienced IPA. To begin the initial interview, all participants were provided with an open-ended question: "I know that you have had experience working with people who have experienced IPA, and you are participating in this study in relation to that. I'd like to start out by asking about how you came to work in the position you are currently in." The remainder of the interview with Phase 1 participants used a semi-structured interview format (see Appendix B.3).

Phase 2 involved conducting follow-up interviews the initial three participants. The follow-up interviews were conducted with the intention of gaining further detail from the participants about their specific experience, specifically about the codes that were arising as significant. Due to the nature of these interviews (i.e., to ask specific follow-up questions regarding their personal experiences), interview guides were not created.

Phase 3 involved conducting interviews with three new participants (see Appendix B.4), who specialized in the area of providing therapy to men who experience IPA. These interviews were performed with the intention of asked more pointed questions regarding the codes which

appeared significant, as well as to gather data about others' experiences in order to work towards saturation of the data. In keeping with theoretical sampling, in addition to the previous questions I also asked about their realization of the importance of this population, and recognition/addressing of biases. Finally, I discussed components of the emerging grounded theory model and used this data to further confirm and/or modify existing codes, categories, and the ordering of phases.

Phase 4 involved interviews with two negative cases. Through consultation with my research supervisor, we determined that it would be helpful to speak with counsellors who work with other stigmatized populations (i.e., a counsellor who works with the 2SLGBTQ+ community, and one who works with individuals who have committed sexual offenses), in order to assess the specificity of my model to men who have experienced IPA, and ascertain if much of my model could be accounted for by the common experience of working with a stigmatized population. After focused coding was conducted, it became apparent that these participants' processes followed a very similar path of those of service providers for men who experience IPA. Thus, this data was used to determine the bounds of the theory, to provide helpful clarification regarding the development of theoretical categories, and to theorize regarding the applicability of this theory to other populations. Interviews with these participants remained the same as with previous participants, though wording was changed to make the questions applicable to the stigmatized population of interest (Appendix B.5).

## **Grounded Theory Analysis**

### ***Open Coding***

I first read through and highlighted sections of the initial transcripts, in order to identify areas which were pertinent to my research topic (i.e., understanding and providing help to men who have experienced IPA). Next, I performed "open coding" where I assigned codes to the pertinent transcript areas. These codes involved ascribing "action" based words and/or phrases to sections of the text, in order to summarize the main point. These codes often included the specific verbiage used by the participant. Next, I reviewed the transcripts and their codes, and looked for similarities across interviews. Throughout this process, I wrote memos regarding similarities between participants, common codes that were recurrent, and my thoughts and feelings about the process. This memoing process helped me to identify a number of codes that were recurrent across participants, and I kept a running list of these.

### ***Focused Coding***

The second stage of analysis involved focused coding. Here, I identified the codes which appeared most frequently, and used them to establish linkages between other codes. I read through all of the transcripts and took note of what themes/codes were arising consistently across participants. I paid close attention to what codes appeared to be pertinent and necessary for participants in their process as a help-provider for this population. I began with the first three participants' interviews and began identifying codes which could be subsumed or combined under a larger, umbrella term (i.e., a category; Charmaz, 2008). This was completed in tandem with coding the three follow-up interviews. Throughout this process I wrote memos regarding which codes should be combined, and initial thoughts regarding category names. This process of memoing allowed me to track my thought process and to see how the categories slowly developed. From this process I then had developed a list of categories and memos about these categories, which enveloped the various codes that I had initially created. I then went through the Phase 2 and 3 interviews and performed further selective coding. Here, I was looking specifically for evidence to confirm the existence of these initial categories that had emerged, and to provide additional context and depth to these categories. Focused coding was also used for the Phase 4 data, and these results were used to further refine the categories. By the end of this iterative process, I had developed a number of theoretical categories which encompassed the initial open codes. Through memoing and constant comparison of the data, these theoretical categories were formed into a synthesized theoretical process regarding counsellors' journeys to becoming someone who provides help to men who experience IPA.

### ***Theoretical Saturation***

Data generation and analysis were conducted iteratively until theoretical saturation was reached. This is "the point in category development at which no new properties, dimensions, or relationships emerge" (Strauss & Corbin, 1998, p. 143). As noted above, data was generated in four iterative phases. I conducted open coding for Phase 1 and 2 interviews. Next, in Phase 3, I engaged in focused coding for three new interviews. Following the first interview of Phase 3, I began to suspect that I had reached theoretical saturation (i.e., no new information/codes were arising from the data). I started questioning whether theoretical saturation had occurred, because there did not appear to be any new information coming from the data (Morse, 1995). For myself, I was no longer surprised at the stories that participants were sharing, or at the answers that they

were providing, because I felt like they were *familiar* – I had heard this information from previous participants. During the coding process as well, although I was attending to possible divergent areas, or areas of difference, they were not arising – the information began repeating itself. In order to confirm this, I interviewed the subsequent two new participants, and performed focused coding on this data. Following these interviews, it became clear that theoretical saturation had been reached. Next, I performed interviews with two negative cases (i.e., individuals who provided counselling to other stigmatized populations), which is an additional requisite to ensuring saturation (Morse, 1995). Focused coding was conducted with these interviews as well, and they were used to determine the boundaries of the categories, as well as to provide further evidence regarding exit points along the model. Constant comparison was used between and within participants throughout this process, alongside memoing, and consultation with my research advisor. As noted above, data saturation appeared to occur around participant four (interview 7).

A number of other considerations were made when determining theoretical saturation. For one, my sample was cohesive and homogenous (Morse, 1995). Specifically, my sample consisted of counsellors in North America, who provided counselling to men who experienced IPA. According to Robinson (2014), this sample has Geographical homogeneity (i.e., North America), and Life-History homogeneity (i.e., counselling training). Morse (1995) notes that homogeneity of your sample will lead to quicker saturation. There is, of course, a trade-off between heterogeneity and homogeneity of samples (Robinson, 2014). Notably, that homogeneity can reduce the generalizability of your findings (Robinson, 2014). However, others argue that having too heterogeneous of a sample means that findings will be removed from real-life settings, and that the sheer diversity of data may lessen the likelihood of finding meaningful core cross-case themes during analysis (Robinson, 2014). Thus, Robinson (2014) suggests that “all researchers must consider the homogeneity/heterogeneity trade-off for themselves and delineate a sample universe that is coherent with their research aims and questions and with the research resources they have at their disposal” (p. 28). For myself, limiting the sample to counsellors in North America allowed me to arrive at conclusions regarding the opinions of counsellors who are from a similar part of the world, and are exposed to similar social scripts, and thus make recommendations for training and service provisions that would be specific and appropriate. Furthermore, homogenizing the sample by only including counsellors ensured that



important nuances of these services providers' experiences were attended to. Incorporating a multitude of service providers would present issues with them having different foci of services and vastly different training backgrounds, thus the diversity of data may lessen the likelihood meaningful core cross-case themes being found during analysis (Robinson, 2014). Yet, this homogeneity was balanced by including a range of ages, types of counselling training backgrounds, diversity of gender, and diversity of experience with this population, which allows for a heterogeneity of sample that still encourages applicability in a variety of cases.

Furthermore, my sample was tailored to a very specific research questions, and I utilized theoretical sampling, both which are important components to facilitate saturation (Morse, 1995). This sample holds the precise knowledge that is necessary to answer the question of the process that service providers go through to become someone who provides help, which will further facilitate saturation. The use of theoretical sampling further ensured that the sample continued to be relevant to the research question and the evolution of the data and analysis. This meant that I was continuously recruiting participants who were able to provide in-depth perspectives regarding my research questions. Furthermore, by the completion of data collection, I had a resulting theory that was comprehensive, understandable, and did not have gaps. It helped to explain the phenomenon under study, it helped to make predictions regarding service provider's behaviours throughout the process, and it made sense in light of previous literature. All which Morse (1995) notes as important indicators of saturation. All of this aforementioned knowledge, and its overlap with the saturation and sampling literature (Morse, 1995; Robinson, 2014) allowed for confidence in my suspicion that saturation had been reached.

Based on my previous description of theoretical saturation, my formal theoretical saturation check involved a number of components. First, I reached a point, as noted above, where no new codes were arising from the data. Second, I reviewed the theoretical categories, and ensured that they complete. This was done through formally writing up the results section and determining whether the categories and their inter-connections were comprehensive and understandable. During this review of categories I also ensured that the theory was comprehensive and provided a clear description of the process that I was investigating. I also had reached a point of feeling like I understood participants and their stories. Last, I conducted a check of the data, to ensure that all participants' voices were captured within the higher-level theoretical categories (see Table 6.1).

## CHAPTER 7: STUDY 2 RESULTS<sup>12</sup>

### Overview

My second grounded theory resulted in an underlying process that counsellors go through on their way to become someone who provides services to men who have experienced IPA. This process involves three phases: 1) Realizing Severity, 2) Wanting to Help, and 3) Forming a Validating Connection. Within this phase of Forming a Validating Connection are the subprocesses of 1) Recognizing Biases and 2) Addressing Biases. It is through these subprocesses that counsellors successfully become someone who is able to Form a Validating Connection with the client, and thereby hypothetically provide effective services. This theory also lends itself to hypothesizing challenges (i.e., “exit points”), which can result in counsellors exiting the model, and not completing the journey towards providing effective services to this population. These exit points are also described below. A visual depiction of the process can be found in Figure 7.1.

### Phase 1: Realizing Severity

All counsellors spoke of a point in their lives where they realized that IPA against men was a serious issue. The point in their journey where this occurred, however, differed per the individual. For some this was early on, prior to entering post-secondary education, or during their training experiences. For others, this realization did not occur until they were well into their careers, often after they had a client disclose that they had experienced abuse from a female partner. The process of Realizing Severity was influenced by a number of factors. Both professional experiences (e.g., having mentors advocating for being open-minded, encountering a man in their practice who has experienced IPA, reading research around different genders’ experiences of IPA) and personal experiences (e.g., having a personal history of abuse, seeing a male family member experience abuse) were noted as influential in participants resolving this phase. For example, one participant described the first time she encountered a man who had experience IPA: “There was a lot of verbal abuse that we saw...done on the girl’s part towards the young man...so that was the first time that I was like you know, it can happen to both people.” Another participated stated: “it actually was a co-worker...that said...if this was reversed

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<sup>12</sup> The three phases and their labels will be discussed below in general terms. However, it is imperative to note that each individual’s experience of journeying through these phases will be unique and idiographic. Experiences and relevance of these phases will vary per each person’s locations of difference. This will be expanded upon in further detail in Chapter 9.

it would be an abusive relationships and there would be more done about it. And that...that sentence itself was like woah. Like we...maybe we need to be doing more. So that was like kind of just a wake-up call for myself.” Yet another participant spoke of how personal experiences were influential: “[talking about a male family member who experienced IPA] it actually made...it real to me as a clinician that this happens.” Successful resolution of this phase was indicated by participants indicating an understanding that IPA happens to men too, that this abuse is severe and should be taken seriously, and that this population requires, and is deserving of, help. Individuals would exit the model at this stage if they have not had the experiences necessary to realize that this is a serious issue.

## **Phase 2: Wanting to Help**

The second phase in this process is when counsellors decide that they are Wanting to Help. Here, participants had realized that IPA against men is a serious issue that requires help, and subsequently went through a phase of wanting to be the person who provides that help. Completion of this phase was influenced by participants recognizing that they have skills to offer (e.g., are trained in therapy), having a personal investment or interest in the topic, and having institutional support (e.g., an IPA counselling program opening their doors to people of all genders). For example, one participant spoke of how personal experiences made them want to help: “I was in an abusive relationship for [years]...it makes me more prone to learn about it from different perspectives because that’s just been my experience....so I have a really big heart for people...who have been through anything whether they’re male, female...like it doesn’t matter. If you experienced it, I’m obviously going to have a bigger heart towards that cause, I’ve, I’ve been there.” Another participant spoke of generally recognizing the importance of the issue and wanting to provide good help: “It seems more the importance of understanding this is because of how it could express itself in a therapeutic context and so I needed to learn something about it in order to be effective as a clinician.” Successful resolution of this phase is indicated by participants entering a field specifically with this population, or, if they are seeing men by nature of their job (e.g., a community program where they see whoever walks in the door), indicating a desire to help and understand this population. Individuals would be expected to exit at this phase if they do not have sufficient skills to offer, do not have a personal interest in the area, and/or do not have sufficient institutional support to be able to provide services to men in abusive relationships.

### **Phase 3: Forming a Validating Connection**

The final phase in this process is Forming a Validating Connection. During this phase, participants have already recognized that abuse against men is a serious issue, which warrants help, have identified themselves as people who are willing and able to provide that help, and now have come to a place where they are working with men who experience IPA. Forming a Validating Connection is a phase which is influenced reciprocally by recognizing and addressing personal biases. Importantly, this typically occurs while counsellors are actively providing services to men who have experienced IPA. Indicators that participants have resolved this phase include open-mindedness to client's experiences, a willingness to listen to the client, approaching IPA from a place of gender-neutrality, validation of men's experiences of IPA, and a willingness to adjust one's practice to meet clients' needs. For example, one participant noted that following successful recognition and addressing of biases: "[he] could show up in the room and actually meet people where they're at, not...project what [he] thought the truth was onto them." Other participants spoke of what necessary components of Forming a Validating Relationship are: "a big part...is that you're meeting the person where they're at, it's not about you it's about them," and "when we make therapeutic alliances with all these clients, always focusing on the problem and the strengths encircling the problem, and the strengths that you work on, you...disregard gender." These indicators noted above are achieved by the ongoing sub-phases of recognizing and addressing one's personal biases, described below.

#### ***Subphase 1: Recognizing Biases***

Within this sub-phase, participants acknowledge the influence that personal biases and societal scripts have on their work with therapy clients. Specifically, participants spoke of recognizing their unconscious personal biases, often towards disbelieving the client and assuming that the abuse was not that serious, as well as biases in their professional work (e.g., not thinking to ask questions about potential abuse in relationships when the client was a man). This typically took the form of participants recognizing the indelible influence that societal stereotypes and gender norms have on their perceptions of their clients. For example: "I think that you know...being pretty social justice oriented I was...pretty doubtful of their stories. I will admit that...I wasn't really that empathetic to begin with, and then I started to think about and unpack that for myself. I was realizing well wait a minute, why am I...not believing them based on my biases, and you know I'm not really hearing what they are saying." This recognition often

took place while in the therapy room with clients, whereby counsellors were met with a client (i.e., a man in an abusive relationship) who directly countered their perceptions regarding the gender norms of IPA: “I think it...just the experience of that one young man made me I guess sort of wake up to the stereotypes that I was carrying and to be...more sensitive to that.”

This process of recognizing biases was influenced by directly working with men who experience IPA, a desire to learn/staying up to date with the literature, institutional support (i.e., an expectation that they are accepting of all gender’s experiences), personal humility, self-reflection, and utilizing supervision and consultation. Participants would exit this phase if they were unwilling or unable to recognize the biases they held towards men who experience IPA.

### ***Subphase 2: Addressing Biases***

Following from a recognition of one’s biases is the process of addressing those biases. This typically took the form of participants conducting additional research in the area, reading literature on men’s experiences of IPA, doing “self-work” where they reflected on their assumptions and biases, and pursuing additional training in the area. Exemplar quotes for this phase include: “When I get somebody that I haven’t necessarily feeling confident about, you know really tailoring the best, the gold-standards for treatment, I look it up, I I check it out, I do some reading, I do the experience, I consult with other clinicians,” “I got into research...because I felt like the training I was getting wasn’t sufficient,” and “I think it had to do some of my own work about unpacking where my ideas were coming from.” Completion of this stage was indicated by participants speaking of how their addressing of biases influenced a shift in how they conduct their clinical practice with this population (e.g., if a male client presented with relationship concerns, remembering to screen for the possibility of abuse). This process of addressing biases was influenced by participants’ having a desire to learn, institutional support, a desire to be an effective clinician, humility, and a desire for client-centered care. Participants typically cycled through this process of recognizing and addressing biases numerous times, eventually reaching a point where they perceived that they were providing competent care, as indicated by the Forming of a Validating Connection. Individuals would exit at this phase if they were unwilling to address the biases that they recognized.

## CHAPTER 8: STUDY 2 DISCUSSION

In Study 2, I aimed to fill a gap in the literature by utilizing grounded theory methodology to develop an inductive theory grounded in the lived experiences of counsellors. My study results indicated a clear process through which counsellors progress on their journeys towards providing services to men who have experienced IPA. This process is comprised of three phases: 1) Realizing Severity, 2) Wanting to Help, and 3) Forming a Validating Connection, with the third phase involving two sub-phases: a) Recognizing Biases and b) Addressing Biases.

### **Facilitators to Help-Providing**

#### ***Realizing Severity***

To proceed through my model, counsellors had to first Recognize Severity of IPA against men. In order for them to desire to provide help to this population, they had to realize that men's experiences of IPA are severe, and that they require help for them. Similarly, research with bystanders suggests that as the severity of the situation increases, bystanders are more likely to intervene (e.g., Fischer et al., 2011). Yet, no research has identified realizing severity of symptoms or presenting concerns as a facilitator specifically for counsellors' decisions to provide help to, or specialize in, a particular population. As such, this is a novel finding that provides valuable insight into counsellors' decision to work with certain populations.

#### ***Personal Experiences***

My finding of the importance of personal experiences on counsellors' career trajectories is supported by the work of previous researchers. Namely, the concept of a "wounded healer" has been thoroughly investigated (Conchar & Repper, 2014; Gilbert & Stickley, 2012; Graves, 2008; Groesbeck, 1975; Miller & Baldwin, 2000; Telepak, 2010). This concept refers to an individual who uses their personal vulnerabilities to facilitate the healing of others (Rice, 2011). Personal experiences with hardships might also influence counsellors' decision to enter the field, by way of a desire to help or protect others who have struggled with similar experiences (Bugental, 1964; Hill, 2007, 2009).

Previous literature on bystander intervention can also provide some important contextual insight into these findings. Dovidio et al. (1991) argued for the importance of the concept of *we-ness* with bystander intervention, described as "a sense of connectedness or a categorization of another person as a member of one's own group" (p. 102). Dovidio et al. (1991) suggested that

the categorization of others as members of the in-group increases the likelihood of helping behavior. As such, we would expect that counsellors who view men who experience IPA as part of their own in-group, would be more likely to express a desire to provide help to them. This hypothesis was corroborated by my results, whereby personal experience with abuse or other stressful experiences increased participants' likelihood of providing assistance to this population.

### ***Professional Experiences***

Participants also noted that their professional skillsets played an important role in their help provisions to this population. For example, participants spoke of how having previous skills with counselling individuals who had experienced trauma, or experience with providing services to men, influenced their desire to provide help to men who experienced IPA. This finding also aligns with previous research regarding motivations to provide counselling, whereby counsellors have reported that awareness of help-related strengths (e.g., being empathic, caring, and kind, being a good listener, and being open minded, nonjudgmental, and accepting) influenced their decision to become a counsellor (Hill et al., 2013).

Further, my results show that participants' clinical experience (e.g., first contact) with men who have experienced IPA positively impacts their desire to provide help. Similarly, in previous research, doctoral students typically cite direct clinical work with clients as a positive experience that crystallized their views of their professional selves (Gazzola et al., 2011). These students claimed clinical experience as the most significant element in forming their professional identities (Gazzola et al., 2011). The term "paradigm cases" has been used to denote a particularly influential professional experience. These cases are "clinical episode[s] that alter[] one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice" (Benner, 1984, p. 296). Similarly, Rønnestad and Skovholt (2002) found that personal experiences of counsellors culminate into knowledge that informs their work with their clients. My research further confirms the influence that paradigm cases can have on counsellor's professional development, namely through fostering both their recognition of abuse severity, and their desire to provide help to this population.

**Contact Theory.** This influence of paradigm cases aligns with contact theory, which posits that intergroup contact reduces prejudice (Pettigrew & Tropp, 2006). Namely, an important strategy for bringing about changes in professionals' perceptions of stigmatized people

involves education and training and providing students and practitioners with direct exposure to stigmatized people (Scheyett & Kim, 2004; Shor & Sykes, 2002). My work provides additional support for contact theory, and for the benefits that can be reaped from increased contact between professionals and stigmatized groups. Further, my results provide novel insight into the mechanisms of change involved within contact theory. Namely, contact appears to serve as a method for professionals to recognize the severity of marginalized people's situations, thereby facilitating their movement through the help-providing process.

### ***Institutional Support***

In addition, I found that institutional support influenced counsellors' desires to provide help. For many participants their desire and/or decision to provide help was fostered by their workplace moving towards providing services to men who experience abuse. In this way, they were able to have first contacts with men who experienced IPA and were provided with training and guidance regarding how to provide effective services to this population. At present, to my knowledge there is no research into the influence of institutional support on desires to provide services to specific populations, or stigmatized populations. As such, my results add incrementally to the field (further discussed in Chapter 9).

### **The Importance of Non-Specific Therapy Skills**

My participants described using an overarching clinical approach consisting of non-specific therapy skills for men who experience IPA, as opposed to solely specific intervention techniques designed for this population. Nonspecific factors are "usually construed as elements of the healer-patient relationship that, while not specific to one particular theoretical orientation, may be responsible for therapeutic change" (Butler & Strupp, 1986, p. 31). These qualities typically include elements such as degree of warmth, acceptance, empathy, and respect (Gomes-Schwartz, 1978). These factors are not simply theorized but have been noted as being important by men who have sought help for IPA. For example, men have described that an important aspect of counselling for them was feeling like the counsellor genuinely cared for them and was concerned about their wellbeing, provided them space to speak and be understood, and believed their story (Roddy, 2014). Furthermore, these qualities have been identified as components of Roddy and Gabriel's (2019) competency framework for counselling men who experience IPA. Namely, counselling characteristics such as confidence, compassion, and being non-judgmental



are thought to be necessary competencies for counsellors to have when working with this population (Roddy & Gabriel, 2019; Shum-Pearce, 2016; Tillbrook et al., 2010).

These findings are important to note for a number of reasons. For one, it is possible that some of my participants were not aware of specific treatment protocols and techniques that are recommended for treatment with this population. This rationale would make sense, considering the dearth of services tailored specifically to this population (Beattie & Hutchins, 2015). Conversely, it is possible that participants view these non-specific therapy skills as the foundation or foci of treatment with this population, as opposed to more specific skills. Clarifying these findings is an important area for future research.

### **Recognizing and Addressing Personal Biases**

The personal side of the therapist has been widely acknowledged as an essential tool in the provision of effective counselling and has commonly been referred to as “self as instrument” (Baldwin, 2000; McWilliams, 2004). Thus, because the personal self is utilized as an agent of change in clinical work, self-awareness and addressing of “personal processes, including unresolved conflicts, family of origin dynamics, cultural biases and worldview [are] important components in the provision of effective psychotherapy” (Pieterse et al., 2013, p. 192).

There is an array of previous research into the role of reflection on therapists’ skill development (Bennett-Levy et al., 2001; 2003). Based on Bennett-Levy et al.’s (2001, 2003, 2009) findings and those of others (Milne & James, 2002; Schön, 1983, Skovholt & Rønnestad, 2001; Thwaites et al., 2015), self-reflection appears to be a standard element of ongoing professional development and eventual expertise. My results corroborate the vital role that self-reflection plays in recognizing and addressing personal biases, and consequently forming strong connections with clients.

Additionally, researchers have highlighted countertransference and personal bias as being important aspects of effective service provision, specifically with men who experience IPA (Gold, 2019; Molloy, 2017). Countertransference is a counsellor’s internal and external reactions to a client that are influenced by the counsellors’ own personal vulnerabilities and unresolved conflicts (Gelso & Hayes, 2007). Countertransference can affect all therapists in the therapy room, as they may be influenced by a pre-conceived belief system and societal stereotypes surrounding masculinity, such as viewing females as the sole experiencers of IPA (Adams & Freeman, 2002; Gold, 2019; Molloy, 2017). This was corroborated by my findings, whereby

many of the biases that participants recognized were those surrounding gender stereotypes. Further, research suggest that an important component of therapists' work with this population is simply acknowledging personal beliefs or biases and how they might be exhibited in the therapy room (Gold, 2019). Additionally, ongoing personal assessment of techniques and training and seeking ongoing consultation or supervision is beneficial in combatting clinical biases, and improving service provisions to clients (Robb, 2006). I will discuss the specifics of these recommendations in the implications section of Chapter 9.

### **Comparison to Previous Theoretical Literature**

In line with Charmaz's (2014) recommendation, I postponed my full review of the pertinent theoretical literature until after this theory had been fully formulated. This allowed me to develop a theory that was relatively unbiased by preconceived notions of what should be involved in the process of becoming someone who provides help men who have experienced IPA. This discussion section is dedicated to comparing and contrasting my resultant theory with what has been theorized in previous literature. As reviewed in Chapter 1, there are a number of theories and concepts which were thought to be relevant to my results. However, there have been no models developed which integrate these concepts and theoretical ideas into a cohesive theoretical process. As such, my grounded theory is the first of its kind to be developed to explain counsellors' journeys towards becoming someone who provides help to this population.

### ***Situational Model***

Latané and Darley's (1970) situational model includes five important steps to a bystander intervening in a situation: a) notice the event, b) identify the situation as intervention-appropriate, c) take intervention responsibility, d) decide how to help, and e) act to intervene. This model, though developed to explain bystander intervention, appears to hold some relevance to counsellors' journeys towards providing help to men who experience IPA. Step A and B of this model coincide with Phase 1, whereby it is necessary to recognize that the situation is severe enough to warrant help.

Step C of the situational model further aligns with Phase 2 of my model, whereby the individual must hold a desire to provide help. Notably, the concept of taking intervention responsibility in the situational model does not appear to be inherent in being a counsellor, but rather they must develop a feeling of responsibility (or a desire) to provide services to specific populations. My study provides additional clarity into this step, whereby wanting to help is

influenced by numerous factors, including counsellors recognizing that they have skills to offer (e.g., are trained in therapy), having a personal investment or interest in the topic, and having institutional support (e.g., an IPA counselling program opening their doors to people of all genders).

Last, Steps D and E align with Phase 3 of my model. However, participants in my study did not describe a specific process of deciding what type of help to provide, likely due to the fact that in contrast to bystanders who can provide various types of help for various types of problems, counsellors provide a specific type of help, typically for mental-health related concerns. However, participants in my study spoke of the process of Recognizing and Addressing Biases, and how these steps influenced the types of help they provided and any adjustments that they made in their clinical practice. In this way, models of bystander intervention appear to be a useful comparison when working towards understanding the process of counsellors deciding to provide help to men who have experienced IPA.

### ***Becoming Empowered***

All components of Sawatzky et al.'s (1994) model appear to align with my results. In brief, this model suggests that students go through a process which involves recognizing gaps in skills, knowledge, and experience. Students then respond to those gaps through acquiring new skills, information, and experience, utilizing supervision to eventually become their own supervisor, feel empowered through changing perspectives, trusting self, developing self-reflection, and eventually feel satisfied with new skills and autonomy. Participants in my study went through a similar process, specifically in Phase 3. Here, participants recognized a gap in their knowledge and skills, addressed that gap through acquiring new skills and/or seeking supervision, and eventually described feeling empowered and competent at developing strong relationships with men who experience IPA. Thus, it appears as if this process of "Becoming Empowered" might be applicable at various stages in a counsellor's development, not solely during the training phase as originally postulated by Sawatzky and colleagues (1994). My model elucidates the life-long developmental and learning journey that being a counsellor entails, suggesting that counsellors might "become empowered" in their abilities after each time they identify and address a knowledge gap.

### ***Phase Model***

Rønnestad and Skovholt (2003) developed a model to describe the phases and central processes of counsellors' development. Although the six phases are not necessarily pertinent to this study, many of the 14 themes of professional development that they identified align with my results. First, the authors described how personal and professional experiences influence professional functioning. My results depict how the professional self cannot be untangled from the personal self, and how these selves influence how counsellors Recognize Severity, Want to Provide Help, and Recognize and Address Biases. Similarly, the authors suggest that extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability. My results similarly show that personal histories of trauma and suffering served to facilitate counsellors' Recognition of Severity, influenced Wanting to Help, and participants noted that it helped them better understand and appreciate diversity of experiences.

Rønnestad and Skovholt (2003) further posit that continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience. Similarly, my results show that reflection is an integral component of Recognizing and Addressing Biases. This process of Recognizing and Addressing Biases was then necessary for counsellors to be able to Form a Validating Connection with their clients. The authors also discuss the importance of an intense commitment to learn, which propels the developmental process. In my model, the sub-phase of Addressing Biases was resolved when participants expressed a desire to learn more about their biases and/or to address the knowledge gaps that they had identified through pursuing additional education in the area. In this way, participants would exit the model if they were unwilling to further their learning.

In addition, the authors noted that professional development is a long, slow, continuous process that can also be erratic, and that it is a life-long process. My results corroborate this claim, as Phase 3 is conceptualized as a "never-ending cycle," whereby participants continuously reflected and recognized and addressed biases or gaps in knowledge, regardless of age, level of training, or years of experience. This process served to facilitate client relationships and treatment, but participants never reached a place of perfection, which indicated a life-long journey of professional development and improving client care. Last, Rønnestad and Skovholt (2003) spoke of how clients serve as a major source of influence and serve as primary teachers. Similarly, in my study participants often described their first experience with a male client who

was in an abusive relationship as a learning experience, and even as a “turning point” for them in realizing that this abuse is a serious experience worthy of help.

### ***Summary***

In sum, the aforementioned models align with numerous components of my model. Yet, none of this theoretical literature clearly outlines the personal and professional journey towards providing counselling services to specific stigmatized populations. Moreover, there is no theory or research background specifically on how counsellors choose who they want to work with, or if individuals even get to choose who they work with. This is a clear gap in the literature, one which is incrementally addressed through my results. Namely, the developed model helps provide insight into what factors influence recognition and definition of presenting problems, what experiences contribute to decisions and desires to provide counselling services to stigmatized populations, and how counsellors provide that help, whilst concurrently recognizing and addressing societally influenced conscious and unconscious biases in their work.

### ***Culture***

As noted in Chapter 2 and 4, practices such as help-seeking, receiving, providing, and experiences such as IPA are influenced by the cultural context within which they occur. As such I want to recognize that help-providing will likely look very different if it were to be investigated in other geographic and/or cultural settings.

### ***Personal Experiences***

Many of the aforementioned phases might be influenced by personal experiences. As noted above, some participants had experienced an abusive relationship, or had a close family member who experienced an abusive relationship. These participants noted that these traumatic experiences played an integral role in Phase 1, where they recognized the severity of abuse towards others, including men. Furthermore, these personal traumatic experiences, as noted above, might act as facilitators for participants’ desire to provide help to this population. Namely, that they want to help others who have had the same difficult experiences as them. In a similar vein, the counsellor who worked with the 2SLGBTQ+ community, and identified as a member of the 2SLGBTQ+ community, indicated that they wished to provide counselling to this population because they understood the difficulties that 2SLGBTQ+ individuals face in their everyday lives.

## ***Gender***

In addition, gender will likely influence how participants move through and experience this model. Hogan and colleagues (2012) found that the counsellors reported male clients who had experienced IPA were afraid of being in the therapy room with a woman. This perception of clients as fearful of working with a specific gender might affect counsellors' desires to provide services to this population (e.g., if women perceive men who experience IPA as unwilling to work with them, then women might be less likely to develop a desire to provide services to this population). In addition, given the aforementioned research that categorization of others as members of the in-group increases the likelihood of helping behavior (Dovidio et al., 1991), it is possible that male gender might present as a facilitator to counsellors' desire to providing help to this population. However, previous literature shows that men tend to be more essentialist (i.e., express greater belief in relatively stable, unchanging, likely to be present at birth, and biologically based components of masculinity and femininity; Smiler & Gelman, 2008). As a result, it is plausible that identifying with a male gender might result in differential experiences of the phases. Specifically through influencing expectations of hegemonic masculinity, which might result in greater difficulty recognizing the severity of men's experiences of IPA and of men as "victims," lesser desire to provide help to this population, greater difficulty recognizing them as needing help, and more salient or difficult-to-address personal biases.

## ***Religion and Cultural Heritage***

Additionally, the traditional definition of culture and cultural locations might differentially affect experiences of the phases of this model. Given the finding that personal experiences influence Realizing Severity and Wanting to Provide Help, it is possible that counsellors who come from backgrounds with different cultural and social norms which support various types of violence, might hold different thresholds for realizing severity of IPA. For example, traditional beliefs that men have a right to discipline or control women, or which accept violence as a private affair might influence how counsellors experience each of the phases along the model (World Health Organization, 2009).

## ***Institutional Culture***

Additionally, training, experience, and institutional cultures can present as important contextual factors throughout the model. For example, mental health professionals with more professional experience (Lauber et al., 2006), training or education (Crawford et al., 1991) and

higher levels of knowledge (Carney et al., 1994) appear to hold more positive attitudes towards various stigmatized populations. However, other research into the influence of type of degree and level of experience on attitudes towards men who experience IPA depicts mixed results (Hanna, 2015; Zeinert, 2017). Although these factors might play an important role, we currently do not understand the method through which they might influence provision of services to men who have experienced IPA. Further, as noted above, institutional support can greatly influence perceptions of severity of men's experience of IPA, desire and/or ability to provide help, and recognizing and addressing of personal biases. Thus, counsellors who have experience with or currently work within institutional cultures which advocate for the gender-neutrality of IPA, are open to providing services to men who have experienced IPA, and which encourage self-reflection and professional development are likely to have different experiences of moving through the model, as compared to those who have not been involved with these types of institutional cultures.

## CHAPTER 9: GENERAL DISCUSSION

### Overview of Dissertation

Men experience IPA from female partners at alarming rates (Tjaden & Thoennes, 2000). This abuse can be severe, and can result in numerous negative physical, mental, and economic outcomes (Berger et al., 2016; Bunge & Locke, 2000; Carbone-López et al., 2006). Yet, men are far less likely to seek help than women (Barrett et al., 2020; Brown, 2004; Cho et al., 2019; Choi et al., 2015; Coker et al., 2002; Drijber et al., 2013; Lachman et al., 2019; Laroche, 2005; Migliaccio, 2001; Mihorean, 2005; Milligan, 2019). Help-seeking can be an integral component of survival and recovery during and following an abusive relationship (Deaton & Hertica, 2001; Kress et al., 2008), and as such, men's hesitance to seek help for IPA is concerning. Researchers have identified various barriers to men's help-seeking (Barrett et al., 2020; Choi et al., 2015; Hines & Douglas, 2011; Liang et al., 2005; Stephenson, 2009; Tillbrook et al., 2016; Tsui et al., 2010; Walker et al., 2019) and have further presented a number of general and IPA-specific models and theories of help-seeking (Ajzen, 1991; Andersen, 1995; Burgess-Proctor, 2012; Cramer, 1999; Fleming & Resick, 2017; Gerrard et al., 2008; Gondolf & Fisher, 1988; Grigsby & Hartman, 1997; Kingsnorth & MacIntosh, 2004; Leventhal et al., 1984; Liang et al., 2005; Pescosolido, 1992; Rosenstock, 1974; Vogel et al., 2006; Walker, 1979). However, none of these models have been developed specifically for men who have experienced IPA, nor have they been grounded in the stories of men who experience IPA. Through my dissertation I aimed to develop a theory of men's help-seeking for IPA, utilizing grounded theory methodology.

Using this approach, I developed a five-phase model that men go through each time that they seek help for any IPA-related concern. These phases included: 1) Experiencing Distress/Abuse, 2) Recognizing Severity, 3) Realizing Limitations, 4) Deciding to Seek Help [Subphase a) Exploring Options, and Subphase b) Weighing Pros and Cons; both which were driven by a feeling of ambivalence towards seeking help], and 5) Obtaining and Engaging in Help.

One well-known barrier to men's help-seeking for IPA is previous negative experiences with services providers. As such, I wanted to investigate this issue from the other side as well – namely from the perspective of counsellors who work with men who have experienced IPA. Within the literature, there is research depicting the biases that counsellors can hold towards this population (Follingstad et al., 2004; Lawrence, 2012; Zeinert, 2017), as well as research



suggesting that there is a subset of counsellors who support and wish to improve the services provided to this population (Hogan et al., 2012; Molloy, 2017; Wallace et al., 2018). Researchers have found that there are various components of professional development which might influence counsellors' decisions to enter the counselling field, and which can influence how they perceive certain populations (Gazzola et al., 2011; Hill et al., 2013; Rønnestad & Skovholt, 2002), and have postulated various theoretical models of counsellors' professional development (Burkholder, 2012; Rønnestad & Skovholt, 2003; Sawatzky et al., 1994). Furthermore, researchers have explained development of improved attitudes towards stigmatized populations (e.g., men who experience IPA), such as via Contact Theory (Allport, 1954; Pettigrew & Tropp, 2006). Yet, there remains a gap regarding the intersection of the two – namely the process that counsellors go through to become someone who provides services to men who experience IPA. Thus, I aimed to fill this gap as well. Using a grounded theory approach, I developed a three-phase model that counsellors go through as they become someone who provides services to men who experience IPA. Namely: 1) Realizing Severity, 2) Wanting to Help, and 3) Forming a Validating Connection [Subphase a) Recognizing Biases, and Subphase b) Addressing Biases].

In this General Discussion I will discuss the results of Study 1 and Study 2 within a broader context. I will first discuss any overlap between the two studies, namely the importance of forming validating connections for this population, and the necessity of realizing/recognizing severity. I will further discuss the theoretical and practical implications of both studies, with a significant focus on the practical, action-based next steps that we can take to improve the help-seeking journeys and experiences of men who experience IPA. I will discuss my findings from Study 1 and 2 in the context of my overarching theoretical lens (i.e., feminist anti-oppressive theory) and my epistemological and ontological positions. I will identify the potential for transferability of both models as well as discuss important areas for future research. Last, I will outline both the strengths and limitations of this study.

## **Intersection between Study 1 and Study 2**

### ***Forming Validating Connections***

The concept of validation arose as a salient factor for both populations. In Study 1, men spoke of how validation significantly facilitated their movement through the theoretical model, particularly when Recognizing Severity of their abuse experience, Realizing Limitations, Deciding to Seek Help, and when deciding whether or not to engage in the help that they sought.

In Study 2, validation arose as a standalone-phase, whereby counsellors indicated that forming a validating relationship with male clients who had experienced IPA was integral to their provision of services to them. This overlap between men's desire for validation of their experiences, and counsellors' belief that validation is an integral component for service provisions to this population is promising, as it suggests a level of cohesiveness across service receipt and provisions.

What appeared to be the most foundational component of men's contacts with service providers, according to my participants, is an early establishment of the working alliance. Moreover, Phase 3 in my counsellor model is focused on the development of a connection and strong working alliance with clients. The therapeutic alliance<sup>13</sup> is an important factor noted throughout the service provision literature (Abbe & Brandon, 2014; Belcher & Jones, 2009; Bertakis et al., 1991; Gibbons & Plath, 2009; Sternlight & Robbennolt, 2007), but has been most thoroughly investigated within clinical and counselling psychology (Baier et al., 2020). Given the plethora of available literature in this area, and my personal background in clinical psychology, I will be discussing my results in the context of the clinical psychology literature on the therapeutic alliance.

Empirical findings suggest that actions during initial contact with clients have a powerful impact on the establishment of the working alliance and client engagement (Bruch, 1974; Macewon, 2008; Martin, 2000; McWilliams, 1999). Bruch (1974) stated that the experience of this initial encounter can determine the course of the helping experience. The working alliance has been found to be related to improved client outcomes (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Labouliere et al., 2017; Martin et al., 2000) as well inversely related to premature termination of services (Anderson et al., 2019; Constantino, 2002) This is particularly strong for those clients who have experienced traumatic events such as IPA (Management of Post-Traumatic Stress Working Group, 2010).

Validation also was a pillar of counsellors' description of effective care with men who experienced IPA. Validation in therapy is defined by Linehan (1993) as "communication to the client that their responses make sense and are understandable within the current context" (p. 222). Validation has been theorized to enhance the process of therapy and facilitate effective

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<sup>13</sup> The terms "therapeutic alliance," "therapeutic relationship," and "working alliance" are often used interchangeably in the clinical and counselling psychology literature and are used interchangeably here as well

outcomes (Lynch et al., 2006). It has been linked to various positive outcomes in therapy, including stronger therapeutic alliances (Bedi, 2006; Bedi & Duff, 2013; Duff & Bedi, 2010), decreased negative affect and heart rate in healthy controls (Shenk & Fruzzetti, 2011) and chronic pain patients (Edlund et al., 2014), decreased negative affect in those seeking dialectical behavioural treatment (DBT; Benitez et al., 2019; Carson-Wong et al., 2018), particularly those with elevated features of borderline personality disorder (Benitez et al., 2019), as well as increased positive affect in those seeking DBT treatment (Carson-Wong et al., 2018). As such, it is understandable that clinicians in my study indicated that validation, and validating therapeutic connections, were important components of counselling with men who have experienced IPA.

Furthermore, with individuals who experience IPA, previous research suggests that due to the nature of their abusive relationship, and the manipulation and denigration often involved clients can have a lack of trust, and increased wariness (Sanderson, 2008). This can include difficulties trusting the service providers' motives and worries that their disclosures of abuse will be used against them (Sanderson, 2008). As a result, in order to better facilitate movement from help-seeking to engagement with help, a significant portion of initial contact should focus on building trust and bolstering a working alliance with the client (Sanderson, 2008). Robby and Gabriel's (2019) competency framework for working with men who have experienced IPA outlines an entire phase dedicated to building trust in the therapeutic relationship. They suggest clients might take up to eight sessions to develop a level of trust and confidence necessary to share their IPA experience.

My dissertation highlights how important both counsellors and men who have experienced IPA consider this validating relationship to be. As such, my dissertation results emphasize this as a vital training point when training counsellors to work with this population. Although most research has been within the therapeutic alliance (i.e., clinical service provision) specifically, researchers have also found that a strong working alliance is fundamental to effective service provisions from police officers (Abbe & Brandon, 2014), nurses (Belcher & Jones, 2009), lawyers (Sternlight & Robbennolt, 2007), social workers (Gibbons & Plath, 2009), and physicians (Bertakis et al., 1991). As such, these results and recommendations can likely be generalized to the broader service provision community as well.

### ***Recognizing/Realizing Severity***

For both Study 1 and Study 2, one of the initial and foundational components of both help-seeking and help-providing journeys was Recognizing/Realizing Severity. This is an interesting finding, as it highlights the influence of the global, or overarching societal narrative discussed throughout this dissertation that abuse against men does not happen or is not severe. As will be discussed in more detail below, the expectation that men cannot be abused is a multifaceted issue. There is a complex interplay between both men and counsellors, who both might have preconceived notions that abuse against men does not happen. These preconceived notions are reciprocally influenced, whereby men are hesitant to seek help due to fear of stigma and ridicule, and due to difficulty recognizing the severity of the abuse. When men do not seek help for abuse, this might then compound or corroborate service providers' preconceived notions that IPA is a "women-only" issue and that abuse against men is not severe. It is evident from these two studies that this narrative can be internalized by both men and counsellors alike; neither are immune to societal stereotypes about IPA and gender.

Recognizing Severity was facilitated for both populations in various ways. As noted above, for both populations this took the form of education materials (e.g., professional development seminars for counsellors, advertisements about abuse for the men) and social support (e.g., institutional support for counsellors, friends and family labelling the abuse for men). A notable difference was that contact with a man who experienced abuse was a facilitator for Realizing Severity for counsellors. However, in Study 1, two men discussed knowing other men who were in abusive relationships, and neither participant indicated that this was a helpful facilitator for them recognizing their own abuse. Rather, they spoke of focusing on the differences between themselves and the other man in the abusive relationship. For example, noting that the other individual's abuse is different, or more severe, or providing other rationales. Thus, contact with a stigmatized person (i.e., a man who experiences IPA), may have different influences depending on whether the stigma is external (i.e., counsellor towards a man who experiences IPA), or internal (i.e., a man who experiences IPA towards himself).

### **Integration with Overarching Theoretical Framework**

As noted in Chapter 2, the overarching theoretical framework utilized for this project was feminist anti-oppressive theory. This framework integrates both anti-oppressive practice and

feminist theories, namely components of hegemonic masculinity, and serves as a guiding lens through which to understand my theoretical models.

### ***Hegemonic Masculinity***

The concept of a patriarchal society is a basic tenant of feminist theorizing and action. Though previously thought to solely disadvantage women (Hartmann, 1981), recent scholarship suggests that the patriarchy can act to oppress individuals, regardless of the gender with which they identify (New, 2001). As a result, men too experience oppression as a result of idealized or essentialized views of what masculinity is (New, 2001). This dominant conceptualization and script of masculinity at present is often referred to by theorists as hegemonic masculinity (Connell, 1997).

This idea of essentialist masculinity can be further explained through the concept of “the hegemony of men” (Hearn, 2004, p. 59). Surman (1994) states: “hegemony is taking one way of seeing things, and convincing people that this way of seeing things is natural, that it is ‘just the way things are’” (as cited in Hearn, 2004, p. 61). The main goal of investigating this hegemony of men “concerns the examination of that which sets the agenda for different ways of being men in relation to women, children and other men” (Hearn, 2004, p. 59). That is, how are men and those around them told that men are supposed to act, and what do these messages entail? In this way, we are able to understand why professionals and broader society responds negatively when men behave in ways that are contrary to societal conceptualizations of hegemonic masculinity. The results of my research provide support for the deleterious effect that the patriarchy and essentialists views of masculinity can have, both on men and on those who endeavour to provide services to them.

**Study 1.** Along every phase of help-seeking, internal and external expectations of hegemonic masculinity presented as barriers for men to seek help for the abuse they were experiencing. First, masculinity was an important barrier for participants to Recognize Severity. Specifically, participants spoke of having internalized the idea that men cannot be abused, which then limited their ability to recognize their experience as severe. The stronger these scripts of masculinity were for participants, the more difficulty they had completing this phase. This is not a surprising finding, given the plethora of research articles centering masculinity as a barrier to men recognizing their abuse experiences and seeking help for them. Researchers suggest that participants’ descriptions of their abuse experiences are frequently fraught with minimization of

the abuse (Migliaccio, 2001, 2002) and portrayals of themselves as dominant (Durfee, 2011), both of which might hinder the man from recognizing the severity of their experience. Previous research has also found that men believe that IPA perpetrated against them is incomprehensible (Simon & Wallace, 2017), a belief that would ostensibly prevent men from recognizing that what they are experiencing is severe and unacceptable.

The threshold for men to recognize the severity of their experience is also influenced by their masculine identity. Research on seeking help for health concerns suggests that many men believe it to be a weakness to pay attention to “minor” symptoms and that the ideal of being “strong and silent” about “trivial” symptoms is a widely adopted practice of masculinity (O’Brien et al., 2005, p. 507). Furthermore O’Brien et al. (2005) found that men not only delayed or avoided treatment for ‘minor’ symptoms, but also suggested that serious symptoms might be trivialised (or overlooked) in order to circumvent challenges to their masculinity. In this way, men’s ability (or willingness) to acknowledge the severity of their symptoms or their experiences appears to be significantly influenced by the masculinity ideologies that they hold, or that are bestowed upon them by society.

The concept of masculinity also presented as a barrier for individuals during Phase 3, Realizing Limitations. Traditional notions of hegemonic masculinity posit that men do not need assistance from others (Collier, 1998). Similarly, research with men in abusive relationships shows that they believe they should be able to cope with the abuse (Roddy, 2014; Tillbrook et al., 2010) or have enough power in their relationships to stop it (Tillbrook et al., 2010). Additional researchers theorize that men’s reluctance to seek help might be influenced by traditional masculine ideologies about the importance of solving problems oneself, whereby rather than asking for help, men insist that, “[i]t’s not that bad. I can handle it on my own” (Addis & Cohane, 2005, p. 640). This quote also outlines the phase-based nature of men’s help-seeking, whereby “it’s not that bad” correlated to an exit point during Phase 2 of my model (i.e., Recognizing Severity), and “I can handle it on my own” correlated with an exit point during Phase 3. In this way, one must first recognize the severity of their concern, in order to realize that they are unable to cope with the concern on their own, and masculinity plays a crucial role in these realizations.

Masculinity further influenced the fear of stigma seen in Weighing Pros and Cons, which also arose as a barrier for men seeking help. This is not a new finding, as there is ample previous

research indicating that men view this as a barrier to seeking services (Choi et al., 2015; Machado et al., 2016; Migliaccio et al., 2001; Simon & Wallace, 2017). This fear of stigma included fear of both service-providers' and the greater community's perceptions of their masculinity. This fear of stigma is not unwarranted, as previous research indicates that service providers and broader society can have prejudicial reactions towards this population (Hines et al., 2007; Sylaska & Waters, 2014).

In addition, many participants noted that a barrier for them seeking help was the consequences that their abusive partner might experience. Participants spoke of feeling the need to protect their partner, and help that would not render consequences to their partner (e.g., counselling as opposed to an assault charge with the police), was more readily sought. This concept has not received much attention in the literature, though Walker et al. (2019) found that men speak of feeling like it is important to protect their partner, and report not wanting any help-seeking endeavours to be detrimental to their partner's image. This concept can be understood through a lens of masculinity, whereby men have traditionally been expected to be the "protector" of their partner (Clatterbaugh, 1997). As such, it is likely that this "con" will be more salient for men who more strongly hold these traditional views of masculinity, or who have been socialized in this way.

Within my research, many men did seek help despite mentions of concerns related to masculinity. As such, what will be important going forward is to understand how men overcome these internal and external expectations of masculinity in order to seek help. Although not fully explored in my study, men did discuss various facilitators, such as severity of abuse, being raised in a family where help-seeking was normalized, and encouragement and validation from social supports. Previous research also provides some insight, as Smith et al. (2008) found a mediation effect of attitudes toward psychological help-seeking on the relationship between traditional masculinity ideology and psychological help-seeking intentions. This suggests that attitudes towards help-seeking (and likely previous help-seeking experiences), might be an important factor in overcoming the reluctance to seek help influenced by masculinity. Moreover, some men in my sample did not mention masculinity as a salient factor affecting their willingness to seek help. This finding serves as an additional area of inquiry, as it would be useful to better understand the experiences of these men who have not felt the internal and external constraints of hegemonic masculinity as strongly as others.

**Study 2.** With regards to the second study, hegemonic masculinity and essentialist notions of masculinity further presented as relevant. First, Phase 1, Realizing Severity, indicates that there is an experience that must occur for counsellors to initially recognize that violence against men is a significant issue. This is in contrast to commonly accepted narratives regarding the severity of women's experiences of IPA. Thus, it is feasible that the severity of men's experiences of IPA is not recognized due to essentialist assumptions regarding masculinity. Namely, hegemonic masculinity posits that men are the aggressors, not the victims (Connell & Messerschmidt, 2005), and this narrative about men's inability to be victimized has been echoed throughout society (George, 1994; Javaid, 2017). As such, it makes sense that society and professionals alike would then struggle to recognize men's victimization from IPA as a serious issue. Unfortunately, service providers are not immune to socialized expectations regarding masculinity.

Second, Phase 2 of Wanting to Help suggests that counsellors and/or their place of employment need to hold a desire to provide help to men who experience IPA. This phase too can be understood as influenced by a patriarchal society, one which centers hegemonic masculinity. For one, hegemonic masculinity is typically associated with characteristics of unemotionality and independence and begets expectations of taking charge and denying need for assistance, as this is a sign of weakness (Collier, 1998). As a result, it is understandable that counsellors might not readily recognize these men's need for help. Further, because of these expectations of hegemonic masculinity, men might deny the need for assistance despite experiencing significance levels of abuse, and this in turn might influence counsellors' beliefs that men's experiences of IPA are not significant, and thus they do not require help for it. Thus, these expectations of masculinity act in a reciprocal fashion, whereby counsellors underestimate the severity of men's abuse experience, and men underreport and minimize, resulting in a global underestimation and under-recognition of the severity and frequency of this issue.

Last, the biases that the counsellors in this model needed to recognize and address were presumably influenced by a patriarchal society, one which upholds essentialist notions of masculinity and femininity. The personal biases involved included disbelieving the client and assuming that the abuse was not that serious, as well as biases in professional work (e.g., not thinking to ask questions about potential abuse in relationships when the client was a man). These attitudes can very clearly be understood as a result of a patriarchal society that champions



hegemonic masculinity as the ideal. As a result, in this sample, expectations of masculinity influenced the counsellor's perceptions of their male clients by producing biases such as disbelief that the man could experience abuse and doubt that the abuse could be serious and causing the counsellor to omit questions regarding abuse in the man's relationship.

### ***Anti-Oppressive Practice***

A second component of the theoretical framework utilized for my dissertation was anti-oppressive practice. There are various components to this framework, one of the most salient being that anti-oppressive work is social justice-focused and should be used to elicit change in society. This social justice focus has guided the entirety of my work. Namely, my predominant aim through my dissertation is to increase awareness about the occurrence of men's experiences of IPA from female partners, and to better understand the help-seeking process in an effort to both develop suitable intervention strategies for men, and to improve the services which are currently available. This translation of theory into practice is at the core of anti-oppressive practice. The specifics of this translation (i.e., notable implications and recommendations for service improvements and developments) are provided in Chapter 9. Second, my application of this theory encompasses an approach aimed at emphasizing the unique, diverse and multiple social locations from which individuals experience the world and oppression. In line with anti-oppressive practices, these locations have been thoroughly discussed above, including SDH, and various other locations of intersectionality.

### **Transferability**

The transferability of my model is an important consideration. With qualitative research, regardless of the paradigm adopted, researchers posit that we must discuss the applicability of our research results beyond the initial research setting – that is, the transferability of research results (Lee et al., 2009; Seddon et al., 2006). “Transferability depends on the researcher delineating the characteristics of the setting under which her results hold, as well as on the reader determining if that setting is similar to the one where she wants to apply those results” (Rodon & Sesé, 2008, p. 7).

### ***Study 1***

Study 1 has the potential to be transferrable to a variety of settings. As discussed above, my theory holds many similarities with previous help-seeking models that have been developed to explain women's help-seeking for IPA. As such, it is likely that my model might provide

helpful insight into other genders' processes of help-seeking for IPA. Furthermore, this model has similarities with other general help-seeking models. Thus it is likely that this model can provide additional depth and insight into the broader realm of help-seeking, and the more specific realm of men's help-seeking for a variety of other presenting concerns. These are promising areas for future research, namely that the boundaries of this grounded theory have yet to be fully determined. Investigating the help-seeking processes of women seeking services for IPA, men seeking help for other presenting concerns, and other general help-seeking instances is a crucial next step. In this way, transferability can be further determined, and the implications of this model for other populations can be solidified.

### *Study 2*

The most notable application of this model is with counsellors who work with other stigmatized populations. As noted above, my model was developed with two negative cases: one counsellor who worked with the 2SLGBTQ+ community, and one who worked with individuals who had committed sexual offenses. Literature suggests that these two populations also report experiencing stigmatization from helping professionals (Alanko et al., 2014; Quintana et al., 2010; Renzetti, 1996; Stiels-Glenn, 2010), and as a result, these counsellors were recruited in an effort to determine the bounds of my model. Notably, their stories appeared to align very closely with those of my participants who work with men who experience IPA. As such, this model appears to show promise as transferrable to counsellors who work with other stigmatized populations. Additional research with counsellors who work with various stigmatized populations is a necessary next step, as it will allow me to further determine the transferability of this model.

In addition, this model might be used to generally explain counsellors' professional development journeys towards providing help to various groups of clients. As noted above, there is a dearth of research into counsellors' journeys towards deciding what populations of people and presenting concerns they would like to provide help to. These results can help to provide some insight into the factors that are influential along this journey and might be used to predict the type of populations that counselling trainees might end up providing services to.

Last, this model holds potential to be transferable to other types of service providers who might provide help to men who experience IPA. Specifically, it is possible that other services providers, such as police officers, child protection workers, nurses, and crisis intervention

workers might proceed through a model similar to what has been presented here. Investigating the applicability of my model to these subsets of service providers will be an imperative next step, in order to further ascertain how best to facilitate acceptance and helpful service provisions amongst a variety of types of service providers, not solely counsellors.

### **Epistemological and Ontological Perspectives**

As described in Chapter 2, I approached my dissertation from a social constructionist epistemological perspective and a relativist ontological perspective. Here I discuss my results through both of these lenses.

Based on my epistemological position, I believe that the knowledge derived from this dissertation project was constructed through interactions with participants and my interactions with the world and the individuals within it (Crotty, 1998). Further, these results might be constructed in entirely different ways by different people (Crotty, 1998). As such, I recognize that the results of Study 1 and Study 2 might look different in different contexts, and when investigated by and with different people. I posit that my developed theories surrounding men's help-seeking and counsellors' help-providing journeys are valid reflections of my participants' realities and provide useful mechanisms through which to predict these behaviours. However, I also acknowledge that my development of these theories and the knowledge that comprised them, was co-constructed between myself and my participants and between my participants and their numerous other social interactions.

Ontologically, I believe that an objective truth does not exist, but instead knowledge is created through shared experiences and relationships with people (Charmaz, 2006). Under this relativist ontological perspective, the two grounded theories I developed are depictions of "a reality that cannot actually be known, but that is always interpreted" (Charmaz, 2006, p. 22). Namely, I posit that there is no objective "truth" regarding men's help-seeking and counsellors' help-providing journeys. Rather, representations and understandings of these journeys are created through interactions with people. As such, the results of my dissertation reflect the participants' world and their personal interactions and interpretations of their experiences, as well as those of my own. As such, these results are not "reality" or "ultimate truth" but are a version or interpretation of the processes of help-seeking and help-providing, which are bound and influenced by social interactions and the context within which they occur.

## Theoretical Implications

### *Study 1*

**Comparison with Leading Theories of IPA Help-Seeking.** With Study 1, the resultant theory builds upon previous general help-seeking and IPA-specific help-seeking theories. Previous researchers have put forward many theories regarding these processes, but none have been developed from the ground up (i.e., inductively), nor specifically for men, suggesting that my study is the first of its kind. I believe that this provides a useful basis for depicting the utility, depth, and accuracy that grounded theory approaches can provide, and hopefully will encourage other researchers to use this methodology in the future. I developed a more micro-level theory that what has been previously postulated (e.g., Liang et al., 2005), by identifying additional steps and investigating the rich lived experiences of help-seeking for IPA. As noted previously, Liang et al.'s (2005) theory is the most comprehensive and well-known theory of IPA help-seeking to date (Burgess-Proctor, 2012). As a result, I used this as the foundational theory to compare my own to. My results provide important insight into additional components of help-seeking, not identified by Liang et al., (2005), such as the need to realize limitations and the multiple considerations that contribute to one's decision to seek help. In addition, although Liang et al.'s (2005) theory was developed for women's help-seeking for IPA, its general alignment with my Study 1 theory suggests that there might be more similarities than differences amongst men's and women's help-seeking journeys.

Furthermore, my theory formulated in Study 1 differentiates between the phase of deciding to seek help, and the phase of obtaining and engaging in help. This is an important distinction that has been missing from previous literature. Henshaw and Freedman-Doan (2009) note that the factors associated with initiating treatment might differ from the factors that predict mental health treatment adherence and engagement, and thus should be clearly distinguished from one another. My findings provide further support for this differentiation, and for the distinctive factors involved in each. Going forward, these results will assist researchers in their understanding of the complexity within these two phases and ideally will serve as a basis for these phases to be researched as separate phenomena.

**Predictive Ability.** The model I developed in Study 1 can also be utilized for its predictive abilities. This is a substantial addition to this field, as a formal theory of men's help-seeking for IPA is yet to be developed. Thus, this is the first of its kind, and will allow for

services providers to predict and understand men's help-seeking journeys. Once service providers are trained in utilizing the model, then they will be better able to know where to intervene and/or how to improve their services. Predicting exit points for this population's help-seeking is integral to working towards facilitating that help-seeking in the future.

## ***Study 2***

**Choices of Career Paths.** The results of Study 2 also add to the theoretical literature surrounding counsellors' decisions to provide help to specific populations. Namely, no previous researchers have elucidated this process whereby a professional decides to provide services to stigmatized peoples. It is an area that has received minimal research attention. Thus, my findings provide an important starting point for further research regarding the specifics of counsellors' career choices. This can be used by researchers in the field to further our understandings of counsellors' decisions to work with other populations, as well as career choices more generally. The results of Study 2 also provide additional evidence for the importance of personal and professional experiences on decisions to provide help (Gazzola et al., 2011; Jensen, 2007; Nissen-Lie et al., 2015; Rønnestad & Skovholt, 2002). My Study 2 model further adds additional theoretical information by identifying two specific mechanisms through which these personal and professional experiences hold influence: helping the clinician to realize the severity of a potential or current client's experience and fostering a desire to provide help.

**Counselling Competency.** Furthermore, there is a dearth of theoretical literature surrounding effective provisions of services to men who experience IPA. What has been done surrounds competency frameworks for service providers (Roddy & Gabriel, 2019; Roddy, 2013), one study on specific therapeutic techniques (Gold, 2019), and research into the importance of recognizing countertransference and bias (Adams & Freeman, 2002; Brosi & Carolan, 2006; Molloy, 2017; Hogan et al., 2012). My Study 2 model adds to this minimal literature base and provides an understanding of the importance of non-specific therapy skills (e.g., validation, therapeutic alliance) for working with men who have experienced IPA.

**Models of Professional Development.** Furthermore, as discussed in Chapter 8, my study corroborates previous theoretical models of professional development. As well the results of Study 2 fill a gap in the literature, where there is a dearth of models of professional development conceptualizing counsellors' entire career journeys (Alves & Gazzola, 2013). Brott and Myers (1999) consider professional identity development to be an ongoing process of maturation that

continues throughout one's career. The results of Study 2 corroborate this and provide evidence for lifelong journeys of professional development and for the opportunity for learning and growth at all points in a counsellors' career. This suggests that further research into the life-long components of professional identity development is necessary.

Last, my model present novel findings regarding the process of "becoming" someone who provides counselling services to a particular population. To my knowledge, there have been no other research endeavours to understand this process. Thus, my model is seminal in the field, and will ask as a foundation for future theoretical research into processes of becoming service providers.

**Support for Contact Theory.** My results upheld the tenets of Contact Theory (Allport, 1954), indicating its continued utility in the field of stigmatization research. However, much of the research surrounding Contact Theory has been experimental and/or theoretical (Carney et al., 1994; Crawford et al. 1987; Lauber et al., 2006; Pettigrew & Tropp, 2006; Scheyett & Kim, 2004; Shor & Sykes, 2002). As such, the results of Study 2 are significant, as they depict a real-world scenario where participants, unprompted, spoke of the integral role that contact with a stigmatized person had on their perception of them.

Previous research with mental health professionals indicates that those with more professional experience (Lauber et al., 2006), training or education (Crawford et al. 1987) and higher levels of knowledge (Carney et al., 1994) hold more positive attitudes towards various stigmatized populations. Researchers have interpreted these findings as evidence for Contact Theory. The mechanisms through which these experiences improve attitudes have been investigated (Pettigrew, 1998), but are lacking in their precision. My Study 2 results thus add further precision to our understanding the mechanisms of change involved in contact/experience with stigmatized populations. My results show that contact with stigmatized populations can help the counsellor recognize the severity of a stigmatized person's circumstances, thereby fostering a desire in the counsellor to provide help. This discovery of the mechanisms of change involved in Contact Theory adds to the theoretical literature base and provides a foundation for further inquiry into these, and additional, mechanisms of change.

### **Practical Implications**

The writings of bell hooks (1991) have been very influential for me, especially as I navigated my dissertation. hooks (1991) stated: "I came to theory desperate, wanting to

comprehend - to grasp what was happening around and within me. Most importantly, I wanted to make the hurt go away. I saw in theory then a location for healing” (p.1). This quote provided inspiration as I decided upon a dissertation topic, as well as motivation during those times when a desire to write was lacking. Thanks to hooks’ (1991) writing, I came to understand the power behind theorizing and realized the importance of adding to the theoretical literature surrounding men’s help-seeking and counsellors’ help-providing journeys. As well, the knowledge that these theories can be used to heal helped motivate me to continue researching and continue writing, despite occasionally feeling as if this project was insurmountable.

hooks (1991) suggests that theory is what allows us to engender change in the world, and this is precisely what I am hoping to achieve through this project. However, “theory is not inherently healing, liberatory, or revolutionary. It fulfills this function only when we ask that it do so and direct our theorizing towards this end” (hooks, 1991, p. 2). As such, the prevailing aim of my dissertation was not simply to develop theories, but to develop theories that can be used to heal and liberate those men who have experienced IPA: theories which will revolutionize the help-seeking and help-providing fields, to make them more accessible, more applicable, and safer for this population. With these goals in mind, the practical implications that result from the theories developed in Study 1 and Study 2 have been at the forefront of my mind since the inception of these projects. Furthermore, this focus on practical implications, liberation, and action-based research is foundational to the anti-oppressive theoretical orientation that I adopted (Moosa-Mitha, 2005). As such, I wanted to hone in on how the information derived from these theories could be used to combat oppression and to inform and elicit real change.

### ***Study 1***

**Increasing Availability of Services.** My results evidence, first, the importance of increasing the availability of services for men who have experienced IPA. Specifically, during the phase of Exploring Options, a common exit point was when men believed that there were no services available to them. It is well discussed in the literature that there is a dearth of services that are developed specifically for men (Beattie & Hutchins, 2015; Gold, 2019). With this in mind, a necessary next step would be to further develop services specific to men who have experienced IPA.

**Increasing Accessibility and Visibility of Services.** As previously discussed, often there were services available, but my participants were not aware of them. The services available to

men who have experienced IPA need to be advertised widely and made readily available. There is limited research into the utility of increased advertisement and increasing awareness of IPA services. However, research in other fields suggests that increasing advertising of available services can help facilitate help-seeking. For example, Konradi and DeBruin (2003) reported that advertising sexual assault nursing services to college students helped to increase students' understandings of sexual assault services and increase their willingness to encourage others to use them (Konradi & DeBruin, 2003). Further research into increasing mental health service usage in Nigeria, showed that raising awareness by using volunteers in communities can increase service use (Eaton et al., 2017).

It is important to also advertise the specifics of help, namely incorporating equal representation of individuals (e.g., gender) and abuse-types (e.g., both physical and non-physical) in content meant to increase IPA awareness. Goffman (1979) notes that advertisements directly impact our lived experiences by influencing conceptions of identity, right and wrong, and acceptable/non-acceptable behaviour. In a similar way, viewing content that normalizes men as people who can experience IPA, and which highlight the varied types of abuse that men might experience, can help to validate these experiences and can lead to a recognition of the severity of them. It is also important that these advertisements make it clear that the services are available for, and will be helpful to, men who experience IPA. Many men in my sample questioned whether the help available would truly be useful for their *specific* situation. This highlights the potential isolation that men feel when they experience IPA (i.e., assuming that their situation is so unique that there likely is not help available for it). As such, making it widely known that help is available for their specific abuse experience as a man can act to facilitate their help-seeking journeys.

**Subsidized Services.** Some of my participants were hesitant to invest time and money in a service that they were unsure would be beneficial. This is important evidence which highlights the need for subsidized mental health services and/or increased insurance coverage for individuals who might need help. Research indicates that greater insurance coverage and/or subsidized services is positively associated with utilization of outpatient mental and substance use disorder services (Mulvaney-Day et al., 2019). Based on this finding, by decreasing the financial costs associated with services we can ideally eliminate one of the “cons” identified by these participants, thereby enhancing the likelihood that they will seek help.



**Confidentiality/Anonymity.** My participants reported that a significant barrier for them seeking help was related to fears of others' perceptions of their masculinity. This finding speaks to potential necessity of providing confidential and/or anonymous forms of support for this population. Men have reported a preference for anonymous forms of help in previous research (Shum-Pearce, 2016; Tsui, 2014). As such, these are viable and important modalities to consider when working towards encouraging men on their help-seeking journeys.

**Validating Men's Experiences of Abuse.** Additionally, the results of Study 1 show that IPA perpetrated against men is still an issue that is difficult for many to comprehend, including the men themselves. A notable finding was that external information regarding the validity of the occurrence of men's experiences of IPA was a useful facilitator throughout the model. Validation of experiences was derived from friends, family, and/or other social contacts who suggested that what the man was experiencing was abusive, or when men spontaneously viewed informational materials which described, in gender-neutral terms, what an abusive relationship might look like. As such, this information suggests that increasing awareness of the occurrence of IPA against men is an imperative next step. This can help facilitate the experience of validation that men can receive from their peers, as well as the likelihood that they might encounter informational materials that help to validate their abuse experience and subsequently facilitate their help-seeking journeys.

Further, the importance of clinicians' use of validation should be incorporated into future competency frameworks (e.g., Roddy & Gabriel, 2019), and should be taught in training programs as a fundamental component of best-practice work with this population. Materials could also be disseminated (e.g., a guide to support a male family member experiencing IPA), which emphasize the importance of using validation when a male friend or family member discloses having experienced IPA. This can assist the man's support system, as well as broader society, in understanding how best to support and facilitate their healing during and following an abusive relationship.

**Recognizing Romantic Feelings for Abusive Partners.** Many participants noted that a barrier for them seeking help was the consequences that their abusive partner might experience. Participants spoke of feeling the need to protect their partner, and of having enduring romantic feelings for me. This finding has important implications for service providers working with this population. Namely, Pocock et al. (2020) suggest that it is pertinent that service providers

understand the value that individuals might place on romantic love in a relationship, in order to ensure strong therapeutic relationships with the individual experiencing and at risk of experiencing IPA.

**Resolving Ambivalence.** My results indicate that Ambivalence plays a significant role in individuals' movement through the help-seeking model. Ambivalence is a key component of Motivational Interviewing (Miller & Rollnick, 2012). With motivational interviewing, the service providers creates an environment that is conducive to change by adhering to five principles: 1) expressing empathy and showing nonjudgmental understanding of the client's perspective, 2) working with the client to acknowledge discrepancy by helping clients explore any gaps between current behaviour, and lives they would like to be leading, 3) after this discrepancy is identified, clients will then make the case for change. It is imperative here that the client, not the therapist, argues for change, 4) the provider rolls with resistance, and accepts the normality of ambivalence, and 5) the provider supports self-efficacy, and encourages the client's sense of the possibility of change (Miller & Rollnick, 2012). This method has been utilized by a variety of service providers, including counsellors (Miller et al., 2004), nurses (Brobeck et al., 2011), probation officers (Walters et al., 2010), and social workers (Wahab, 2005). As such, it is a method that might be useful for a variety of service providers when working with men who are experiencing ambivalence about seeking help for concerns relating to their abusive relationships.

**Predicting and Understanding Men's Help-Seeking Behaviours.** An additional implication of this research is the potential for disseminations of the Study 1 model to various service providers. This is an important implication, as it aligns with the anti-oppressive and feminist theoretical orientation that I conducted the research from, and I believe pays homage to the participants through actively working to ensure that this model is being used to improve their help-seeking experiences. Disseminating this model should involve a hands-on group training approach, whereby service providers are introduced to the model itself, taught how to assess and determine where along the model a client might be, and then provided opportunities to practice predicting and understanding men's help-seeking journeys with it; for example, through using vignettes with example cases. A useful vignette might be a man presenting to a service provider with an unrelated concern, and a service provider questioning whether this individual might be experiencing IPA. From there, service providers can discuss how they might assess what phase in the model the client is at, what social locations and other contextual information should be

considered when understanding their experience of the model, and from there develop options to facilitate either entry into, or continuance of, men's journey through the help-seeking model.

## ***Study 2***

**Practitioner Training Programs.** In addition, the model I developed in Study 2 should be disseminated to training programs (e.g., in clinical and counselling psychology, in social work), in order to help program directors better understand the development of counsellors' attitudes and decisions to work with this population. This model can then be used as a starting point for programs to develop and/or further incorporate additional training. For one, results of this study uphold Contact Theory (Allport, 1954), and thus suggest that in order to facilitate better service provisions to men who experience IPA, trainees should be provided with opportunities to work directly with this population. The results of Study 2 indicate that this direct exposure can help facilitate successful resolution of Phase 1, Realizing Severity, and can also contribute to the resolution of Phase 2, Wanting to help.

Furthermore, dissemination of this model can help to influence the incorporation of further training in self-reflection into counselling training programs, as well training for other service providers who might work with this population. One example of how this might be implemented is via Bennett-Levy's (2006) Declarative-Procedural-Reflective (DPR) model. This model identifies counsellors' knowledge and skills and describes how they are developed and cultivated within and across the DPR systems (Bennett-Levy & Thwaites, 2007). Based on this model, Bennett-Levy et al. (2001, 2003) developed the Self-Practice/Self-Reflection (SP/SR) training protocol to explore the role of the reflective system on counsellors' skill development. The SP/SR is a structured training tool, where psychological interventions are applied to the self in SP, and the experience is reflected upon in SR (Chaddock et al., 2014). Chaddock et al., (2014) notes that research with SP/SR indicates that it is related to perceived gains in conceptual understanding and skills (Bennett-Levy et al. 2001; Haarhoff et al. 2011), therapist technical skills (Bennett-Levy et al. 2001, 2003), and therapist interpersonal skills such as empathic attunement and reflective skills (Bennett-Levy et al. 2003). These empathic attunement and reflective skills might be a particularly relevant gain, given my results which emphasize the importance of validating therapeutic relationships with men who experience IPA, and highlights reflexivity as a pillar of this relationship. As such, because my results indicate the imperative nature of self-reflection and continued professional development, these areas should be

encouraged for all counsellors, at all stages of their career. The SP/SR model is an excellent way to facilitate and encourage self-reflection and associated bias recognition and attendance.

Additional methods of encouraging self-awareness in counsellors and counselling-trainees have also been previously postulated. One approach is personal development groups (Lennie, 2007; O’Leary, 1994). However, the research on personal development groups is mixed, with some studies showing increases in trainees’ self-awareness (O’Leary, 1994) and others proving to complicate the self-awareness enhancement process (Lennie, 2007). Another approach to increasing self-awareness in counsellors is encouraging individual therapy (Norcross, 2005). Research into the efficacy of individual therapy suggests that therapy can help the clinician identify “emotional blind spots and hypersensitivities”, enhances recognition of the impact that one might have on others, and increases ability to “recognise, accept, and work to correct one’s inevitable human weaknesses and limitations” (Oteiza, 2010, p. 227). Last, appropriate use of supervision is shown to be an important facilitator for self-awareness and reflectivity (Vallance, 2004). Many of these approaches were indicated by participants in my study as being important in their own self-reflection abilities. As such, my results support an additional call for implementation of further self-reflection training opportunities for counsellors throughout their careers.

Additionally, the results of Study 2 highlight the conscious and unconscious biases that can influence our practice. Specifically, many counsellors spoke of their assumptions regarding the gendered nature of IPA (i.e., that it is predominantly male-perpetrated) and of how these assumptions were often corroborated through their post-secondary training. Thus, implications from my results include a call for incorporating a gender-neutral approach to discussing and teaching IPA theory to trainees. In this way, trainees can be introduced to the issue of men’s experiences of IPA from female partners and can begin their journey of recognizing and addressing those societally influenced biases regarding essentialist masculinity and the gendered nature of IPA.

Importantly, these training opportunities should not solely be limited to service providers-in training. The results of Study 2 indicate that the phases can be successfully resolved at any stage in the counsellor’s career. Thus, these findings also have implications for developing training programs for those clinicians who have already begun their careers, in order to further facilitate their movement along the model. This is significant, as counsellors may encounter a

man who has experienced IPA in their practice regardless of whether or not they specialize with this population. Furthermore, these results could be applied to other service providers as well.

**Addressing Biases.** Previous researchers have identified a wealth of recommendations for addressing bias in our work. One approach includes using standardized methods, particularly when conducting intake interviews and assessment, can help to limit the influence of personal biases on interactions with clients (De Kock & Hauptfleisch, 2018). Furthermore, a common recommendation for debiasing is that counsellors develop an understanding of basic Bayesian statistics, especially with base rates of phenomena (Arkes, 1981). Specifically, if counsellors are aware that the rates of men's victimization from IPA are high (e.g., 19% as per Desmarais et al., 2012), regardless of how they compare to women's victimization, this might assist to combat personal biases that counsellors might hold regarding base rates of gendered-IPA experiences, and regarding the severity of this abuse. These methods should be employed in clinical practice, in efforts to address the pre-existing biases that counsellors might hold.

**Improving First Contacts with Clients.** The results of Study 1 and 2 provide clarity regarding our understanding of the imperative nature of first contacts with counsellors. My results depicted a clear separation between seeking and engaging in help, whereby an intake session with a counsellor or other service provider does not necessitate full engagement with that professional. Research indicates that actions during initial contact with clients have a powerful impact on the establishment of the working alliance and client engagement (Bruch, 1974; Macewon, 2008; Martin, 2000; McWilliams, 1999). Bruch (1974) stated that the experience of this initial encounter can determine the course of the helping experience. The working alliance has been found to be positively correlated to improved client outcomes (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Labouliere et al., 2017; Martin et al., 2000) as well inversely related to premature termination of services (Anderson et al., 2019; Constantino, 2002) These relationships are particularly strong for those clients who have experienced traumatic events such as IPA (Management of Post-Traumatic Stress Working Group, 2010).

In addition, the results of Study 2 indicate that validating, trusting relationships with this population is foundational to providing services to them. Based on this information, I recommend that service providers focus greatly on building that therapeutic alliance with the client during the initial contact. This will then ideally assist in increasing the client's engagement, and likelihood of continuing with services.

Furthermore, a number of my participants reported that fear of stigma from service providers is a significant barrier for them. Many participants described seeking help for abuse-related concerns (e.g., lawyers for custody battles, psychologists for depressive symptoms), but not disclosing to that professional that they were in an abusive relationship. This finding suggests that many service providers are likely working with men who are in abusive relationships but who have not disclosed this information to them. This finding highlights the importance of making sure to open the door for clients to disclose (e.g., by normalizing the experience, by including abuse-specific questions in intakes and assessments). This finding also emphasizes the importance of ensuring that the door is perceived as open for the entirety of therapy, in case men do not disclose at initial contact (as my results suggest).

In addition, findings from Study 1 indicate that previous negative help-seeking experiences act as a significant barrier during the transition from Phase 4 to Phase 5. Thus, the potential of clients having previous negative experiences should be at the forefront of service providers' minds when a man initiates contact with them. In this way, service providers can work to address the ways that these previous negative experiences might prevent a man from engaging further in services, for example, through having an open discussion about any concerns the man might have about seeking help again.

### **Strengths & Limitations**

There are a number of strengths with my dissertation. For one, both studies were grounded in the participants' lived experiences. This is a significant strength as this approach (and other qualitative methods) produce detailed descriptions of participants' feelings, opinions, and experiences (Denzin, 1989). This allowed me to attend to and interpret the nuances and contexts that were inherent in each participant's story, thereby increasing descriptive depth and understanding. In addition, the populations that I interviewed were specifically matched to the research question. This is an important strength, as the results were garnered from those who have the most insight into the issue at hand. This allows us to draw very specific conclusions, and to have confidence in the likely applicability of these findings to these populations (Morse, 1995). Furthermore, the heterogeneity of the sample is a notable strength. Namely, the participants recruited in Study 1 had a broad range of ages, were involved in a variety of abuse relationship pairings (e.g., married, dating), experienced a diversity of types of abuse (e.g., physical, sexual, emotional), both had children and did not, and the time passed since the end of

the abusive relationship also varied. This heterogeneity is considered a strength, as we can understand the theoretical model to be applicable across ages, relationship types, abuse types, relationship pairings, and time points in healing journeys (Robinson, 2014). Similarly, the heterogeneity in Study 2 proves to be a strength, as the theoretical model can be interpreted as being applicable across years of experience, age, training programs, and gender. An additional strength is found in the nature of the studies themselves; through both studies I developed predictive and explanatory theories, and as a result these theories can be utilized by both researchers and clinicians for further theory development, and implementation of change.

In addition to these strengths, there are some limitations that I must note. First, it is likely that there was a component of social desirability bias occurring during the interviews in Study 2. Although this was not formally measured, it was expected, as researchers have found that self-reports of competence may be vulnerable to social desirability bias, because of norms which dictate that it is inappropriate to stereotype or negatively evaluate others based on group membership, such as ethnicity or gender (Larson & Bradshaw, 2017). With Study 2 participants, this social desirability might also have been compounded by having myself, a graduate student in a similar field, conducting the interviews, given the small counselling and psychological community.

Furthermore, there was the issue of some dual relationships with participants in Study 2, also as a result of the small professional community in the surrounding area, which might have played a role in participants' willingness to disclose, and/or in the way that participants presented information. In addition, upon reflection, my research supervisor and I observed that the data gathered from Study 2 appeared to be lacking in depth, as compared to the data from Study 1. This observation arose first from comparing the Study 1 model with the Study 2 model and realizing that the level of detail and understanding of the phenomenon under study seen in Study 1 was not evident in Study 2. As above, this is likely a result of the nature of the population under study. Specifically, I was interviewing professional counsellors regarding counselling experiences and career trajectories, which might have resulted in a hesitancy to disclose more personal and in-depth information about themselves.

Last, with regards to Study 1, a limitation is that I was unable to draw abuse-type-specific conclusions. As noted above, the heterogeneity of the sample is thought to be a significant strength, but as Robinson (2014) notes, there is a trade-off between heterogeneity and

homogeneity of samples. Thus, although heterogeneity of abuse types is a strength, it can also act as a limitation. Kelly and Johnson (2008) suggest that differentiating amongst typologies of IPA (e.g., Johnson, 1995; 2006) is necessary so that appropriate and accurate screening instruments and processes can be developed, and as such this is an area for further inquiry.

## **Future Research Directions**

### ***Formalizing Theory***

There are several future directions that stem from my dissertation. First, within grounded theory literature, researchers speak of the development of “formal theories” following an initial grounded theory. “A formal theory generation requires a full systematic comparison of two or more well-generated substantive theories based on enough participants to show established patterns” (Glaser, 2014, p. 50). For example, a theory of becoming a nurse can be formalized by comparing it to other theory and data about “becoming a doctor, becoming a lawyer, becoming a pilot, becoming an accountant, etc. to arrive at a theory of becoming a professional” (Glaser, 2007, p. 99).

With this understanding in mind, an important future direction for Study 1 would be formalizing it by comparing it to other theory and data about women seeking help for IPA and people in other groups (such as the 2SLGBTQ+ community) seeking help for IPA, to arrive at a theory of seeking help for IPA. More broadly, it could be further formalized by comparing it to other theory and data about seeking help for cancer, seeking help for injury, seeking help for mental health concerns, etc., to arrive at a more general theory of seeking help.

A similar approach can be taken with Study 2, whereby a theory of becoming a counsellor who provides services to men who experience IPA can be formalized by comparing it to other theory and data about becoming a police officer who provides service to men who experience IPA, becoming a social worker who provides services to men who experience IPA, becoming a nurse who provides services to men who experience IPA, etc., to develop a formal theory of becoming a professional who provides services to men who experience IPA. More broadly again, this could be further formalized to include professionals who provide services to the 2SLGBTQ+ community, professionals who provide services to people who have committed sexual offences, professionals who provide services to people who are living with HIV/AIDS, etc., to develop a broader formal theory of becoming a professional who provides services to stigmatized populations.



Similarly, it will be beneficial to further develop the Study 2 model by speaking with those service providers who do not support service provisions to men who have experienced IPA. This is a specific group of “negative cases” who might be able to provide additional context and insight regarding reasons why counsellors might exit the model. Understanding why some individuals do not support or provide help to men who experience IPA will provide imperative insight regarding how to better address this issue.

### ***Understanding When Help-Seeking is Necessary***

A second area for future inquiry is furthering our understanding as to when help-seeking for IPA is necessary, versus when help-seeking is not necessary. In Study 1, participants spoke of times when they thought help-seeking to be beneficial, or looking back wished that they had sought help, as well as times when they did not think that help-seeking was necessary. This is an important point, as not everyone who experiences IPA necessarily has to fully complete this model – we do not want to pathologize everyone and their experience and we do need to recognize the personal resilience and coping skills that individuals hold. As such, broadly recommending help-seeking for this population is not as straightforward as it appears in the literature. It would be useful to develop an understanding of what circumstances men believe warrant help-seeking and which they believe they are able to cope effectively with, in order to best develop service provisions. This would be valuable information, particularly when further interpreting Phase 3 of Realizing Limitations. Knowing what men believe their limitations to be will be instrumental in further developing services specifically tailored to their needs.

### ***Understanding Self Defense***

Research into the prevalence of Violent Resistance (VR) should take into consideration the potential societal pressures which might prevent men from describing their actions as self-defence. Furthermore, this discussion highlights the unclear boundary between Mutual Violent Control (MVC) and VR. Further research is necessary in order to more clearly describe temporally and behaviourally, what can be categorized as VR, and what should be deemed MVC. Differentiating between the two is important, particularly for the individual experiencing the abuse, as viewing one’s actions as self-defence versus as abusive behaviour is likely to influence their willingness to seek help, in the sense that there might be less fear of legal repercussions in the situation of VR.

### ***Self-Help Modalities***

Previous research is mixed regarding whether self-help modalities are preferred by men, compared to other formal methods of help (Ellis et al., 2013; Mahalik & Rochlen, 2006). Research suggests that they prefer information help-seeking sources, such as the Internet, which too can be viewed as a form of self-help (Lane & Addis, 2005; Tsui, 2014). As evidenced in Realizing Limitations, my participants indicated that they typically preferred to attempt to help themselves prior to seeking out more formal sources of help. However, if these self-help endeavours did not work, then men would Realize Limitations and would proceed through this model. These findings have important implications for developing support services for men that align with their preferences. Specifically, if men prefer to initially attempt to deal with the abuse on their own, this suggests that resources which provide more control to the individual experiencing abuse, such as self-help books or online resources might be a useful initial method of help. Additional research into these preferences is necessary to develop support services for men that align with their preferences.

### ***Informal vs. Formal Sources of Help***

Furthermore, future researchers should consider investigating more in depth the factors involved in decisions to seek formal and informal sources of help. Previous research provides some insight into this decision but does not yet delineate the process involved in deciding between the two, or in engaging with both. This is an important next step, particularly with this model, as social support and informal sources of help arose as significant factors throughout the journey, but the scope of this dissertation project did not allow for thorough investigation of the specific mechanisms through which they act.

### ***Johnson's Typologies***

As well, it will be important to further investigate how Johnson's typologies influence the help-seeking model. As noted above, these typologies were not specifically differentiated during the data collection process, which did not allow me to make any interpretations as to their potential influence on men's help-seeking. As noted above, Kelly and Johnson (2008) suggest that differentiating among typologies of IPA (e.g., Johnson, 1995; 2006) is necessary so that appropriate and accurate screening instruments and processes can be developed. They note this can lead to better decision making, appropriate consequences and sanctions for abusers, and more effective treatment and recovery programs, which can be tailored to the different typologies

of IPA. For example, typologies appear to predict outcomes of abuse (e.g., extent, severity, and after-effects), and thus can assist service providers in referring individuals to appropriate services (e.g., couples counselling versus police intervention; Kelly & Johnson, 2008). As such, it might be beneficial in the future to ascertain how this help-seeking process differs according to abuse typologies.

### ***Competencies when Working with this Population***

With Study 2, an important area for future inquiry is furthering our understanding of competencies when working with men who have experienced IPA. Phase 3 of this model highlights a fundamental component of treatment but does not fully expand upon the mechanisms and specifics of treatment. Roddy (2013) and Roddy and Gabriel (2019) have begun investigating this issue via developing a competency framework for counselling with men who have experienced IPA. This work should be furthered through developing additional treatment protocols and guidelines for providing counselling to this population, as well as through investigating best-practice approaches amongst other professionals who these men might encounter.

### ***Contact Theory***

As noted above, a notable difference between Study 1 and Study 2 was that contact with a man who experienced abuse was a facilitator for Recognizing Severity for counsellors, but not for men. Thus, it appears that contact with a stigmatized person (i.e., a man who experiences IPA), might have different influences depending on whether the stigma is external (i.e., counsellor's stigma towards a man who experiences IPA), or internal (i.e., a man who experiences IPA stigmatizing himself). The mechanisms at play in this process require further investigation.

## **Conclusion**

In conclusion, men experience IPA from women at significant rates (Tjaden & Thoennes, 2000), and this abuse can be severe and can have serious, deleterious effects on men's emotional and physical health (Berger et al., 2016; Bunge & Locke, 2000; Carbone-López et al., 2006). Yet, men are hesitant to seek help for this abuse (Barrett et al., 2020; Brown, 2004; Cho et al., 2019; Choi et al., 2015; Coker et al., 2002; Drijber et al., 2013; Lachman et al., 2019; Laroche, 2005; Migliaccio, 2001; Mihorean, 2005; Milligan, 2019). Seeking help from service providers can play a significant role in facilitating safety and healing following abuse (Deaton & Hertica,

2001; Kress et al., 2008). However, we know from the literature that men's experiences with service providers are not consistently positive (Bates, 2018; Brogden & Nijhar, 2004; Cook, 2009; Douglas & Hines, 2011; Eckstein, 2009; Hines et al., 2007; Machado et al., 2017; Migliaccio, 2001; Stephenson, 2009; Tsui, 2014; Walker et al., 2019), despite there being a subset of counselling professionals who wish to provide effective and safe services to this population (Hogan et al., 2012; Molloy, 2017; Wallace et al., 2018). Through a review of this literature, I thought it beneficial to better understand the processes involved in seeking help in the context of IPA, and in becoming someone who validates men's experiences of IPA and is willing to provide counselling to them.

As a result, through this dissertation project I focused on identifying the processes involved in help-seeking and help-providing in the context of men's experiences of IPA. I endeavoured to develop a theoretical model, using grounded theory methodology, of the process that men go through to seek help in the context of IPA, and of the process that counsellors go through to become someone who provides services to men who have experienced IPA. I developed these theories through conducting semi-structured interviews with participants. For Study 1, this involved interviews with 10 men who had experienced IPA: eight of whom had sought help, and two of whom had not. The results of Study 1 depicted a five-phase process that men go through, each time that they seek any type of help, for any type of IPA. These phases included: 1) Experiencing Distress/Abuse, 2) Recognizing Severity, 3) Realizing Limitations, 4) Deciding to Seek Help (Subphase a) Exploring Options, and Subphase b) Weighing Pros and Cons; both which were driven by a feeling of ambivalence towards seeking help), and 5) Obtaining and Engaging in Help. For Study 2, I recruited 8 participants who provided counselling services to stigmatized populations: six of whom provided counselling services to men who have experienced IPA, and two of whom provided counselling services to other stigmatized populations. The results of Study 2 depict a three-phase process that counsellors go through, as they become someone who is willing to provide services to this population. Namely: 1) Realizing Severity, 2) Wanting to Help, and 3) Forming a Validating Connection (Subphase a) Recognizing Biases, and Subphase b) Addressing Biases).

The results of Study 1 align with previously postulated models of both general and IPA-specific help-seeking (e.g., Liang et al., 2005). However, this developed model adds further depth and clarity regarding the specific processes involved in men seeking help for IPA.

Specifically, the phase of Realizing Limitations and the complexity described in Phase 4 of Deciding to Seek Help are novel findings and add incrementally to the literature surrounding men's help-seeking for IPA. This model can be used to help service providers predict and subsequently address exit points for men in their help-seeking journeys. It further provides clarity regarding what needs to be addressed societally in order to further facilitate men's help-seeking. This includes areas such as increased accessibility and visibility of services, changing narratives regarding essentialist masculinity and acceptable masculine behaviours, and improving the service provisions themselves to encourage future returns to help-seeking.

The model developed through Study 2 corroborated previous theoretical literature, which holds that professional and personal experiences are salient factors in counsellors' professional identity development. However, this model adds to the literature as it allows for a description of the mechanisms through which these experiences affect professional development. Further, this model is unique in its description of the decision-making process counsellors go through in determining which populations to work with. This is a novel area of research, one which provides an ample starting point for future inquiry in the area. This model can be used to predict when and why counsellors might choose to, or not to provide services to men who have experienced IPA and can be used to guide development of training and continuing education programs for professionals, in order to encourage better service provisions for men who have experienced IPA.

The developed theories hold endless implications for improving the help-seeking and receiving experiences of men who have experienced IPA. The exit points involved in these theories help further our understanding of what prevents men from continuing through the help-seeking model, and what might prevent counsellors from being willing to provide services to this population. These are significant and novel contributions to the field of men's help-seeking for IPA, and for improvements of service provisions to this population. An understanding of these exit points engenders possibility for preventing departure from these models. Namely, these models provide us with knowledge of the factors which can cause men and counsellors to egress the model and can help to propagate ideas regarding how best to address these barriers. This is all done with the intention of increasing help-seeking amongst men who have experienced IPA, and of making their help-seeking experiences safer, easier, and more beneficial for them.

## CHAPTER 10: REFLEXIVITY

An unknown number of my life experiences and personal qualities might both consciously and unconsciously have affected this research process. First, I developed an interest in this topic through hearing various accounts, both personally and professionally, from men who had experienced IPA. This fostered a desire in me to develop a greater understanding of men's experiences, society's reactions towards them, and ways to better promote healing for these individuals. Further, as a graduate student in clinical psychology I have a personal and vested interest in ensuring utmost competence and care when providing services to clients. This includes competencies in areas such as sexuality, culture, and gender. For this reason, I recognized that I have felt critical when hearing about professionals providing services to client populations with whom they did not have the proper training and/or with populations against which they hold negative biases. My vested interest might have influenced my interview responses and interpretations of the resulting data, whereby I would be inclined to encourage discussion of competent therapeutic work, and less inclined, or more judgmental when I heard of work that was less competent. In order to minimize this potential as much as possible, I worked closely on my interview questions (for each iteration) with my research supervisor, completed memos reflecting on my interview experiences, and processed and discussed these experiences with my research supervisor.

Further, because of my background in Women's and Gender Studies, I was concerned I might have a different understanding of certain concepts and ideas than my participants. This includes the belief that gender is a social construction and egalitarian views regarding the rights and gender roles of male, female, and non-binary individuals. Thus, I recognize that these beliefs might have influenced the development of interview questions and the language that I used with my participants, and therefore could have influenced the responses that I received. Further, my position as a feminist researcher likely affected how I posed my questions and how I responded to participant responses, as I do believe that all individuals' experiences of IPA should be treated equally in social service sectors, should be free from judgment and discrimination, and that all should have equal access to social programs and mental and physical health services. Last, because I collected interview data simultaneously from both counsellors and men who have experienced IPA, it is possible that the stories I heard from one group of participants (e.g., men who experience IPA) might have influenced my framing and interpretation of the other group's

(e.g., counsellors') stories in a way that might not have occurred if I had collected them sequentially.

An additional area of reflexivity that should be acknowledged is the preconceived notions that I held regarding the research questions for this dissertation. I went into the project expecting there to be men who simply seek help for IPA. Many researchers of this topic speak very generically about seeking help, and thus I expected it to be a very straightforward process. However, as I collected data, I realized that help-seeking is an incredibly multi-faceted process. The men in my sample did not state that they simply "sought help for IPA" but spoke of varied times where they sought out help for issues related to, or that occurred within the context of, IPA. I also expected help-seeking to be from mental health providers, but it ended up including a variety of service providers. These realizations resulted in me refining my research questions and adjusting my expectations regarding what results might come from this project. I adjusted my view of this project towards understanding help-seeking in the *context* of IPA, and developed an understanding that men seek help at various times, for various reasons, from various service providers. This includes during and after the relationship, for issues relating to themselves, their partners, and their children, and from counsellors, police officers, nurses, social services, and the legal system, among others.

I also am reflective on the process of developing interview questions for participants. Given the sensitive nature of asking about participants' abuse experiences and the social-desirability inherent in asking about service-provisions, this was a difficult process for me. I had to navigate how to ask participants about why they chose not to seek help without sounding like I was judging them for this decision. I also asked counsellors about whether they hold any biases towards men who experienced IPA and whether this influenced their practice, an equally sensitive and difficult conversation to navigate. I worked with my research supervisor to develop a way of asking these questions that hopefully did not portray any level of judgment to the participants who I asked these questions of. I also worked to frame these questions in ways that portrayed understanding and normalization of their experiences: of the decisions to not seek help, and of the ubiquitous influence that social norms have on clinicians and our work.

As was described in Chapter 2, I made the decision to not engage with the pertinent theoretical literature, prior to conducting these dissertation projects. This was due to my awareness that I would likely struggle not to "fit" my data into other theories that I had

previously reviewed. Looking back, this was a good decision, as the grounded theory process lent itself to a lot of uncertainty. I often did not know where my data was leading and felt lost at times. I am sure that during these times of feeling lost, if I had previous ideas of help-seeking theories, I would have fallen back on them, and either consciously, or unconsciously drawn on them for my results. Rather, by reviewing the theoretical literature after my results were complete, I was able to prioritize my data over assumptions that might have arisen from the literature. This allowed me to engage with it more critically. For example, much of the previous literature was about masculinity and help-seeking for IPA, and my understanding of it was that help-seeking was a linear process and occurred once during the abuse experience. However, as noted above, as I analyzed my data I realized that men seek help for a variety of concerns related to IPA, and that these concerns can occur at multiple times during and after their relationship. As such, I had to adjust my expectations for the process and results. Specifically, I had to be flexible and allow my pre-conceived conceptualization of help-seeking to change so that the model could adequately reflect help-seeking from various service providers, for various reasons, at various times in the IPA experience.

A further significant influence on this research process was my relationship with my research supervisor, Dr. Cummings. We met frequently to discuss the development of the project, the research questions, data collection, and data analysis. It is important to note that her perspectives and opinions also very likely influenced the research process. She too initially understood help-seeking as being quite linear, and originally conceptualized it as being predominantly from counsellors. This assumption was likely influenced by her role as a psychologist and mine as a psychologist-in-training. My research supervisor also has numerous years of experience as a psychologist, and thus has knowledge and practice with some of the specifics of psychologists' professional development and client-work; Dr. Cummings' work on self-care, in particular, is closely related to the literature on psychologist development and she is familiar with some of these development models. I further have four years of clinical training through practica and thus have experience working with clients, some who are from stigmatized groups, and experience in developing my own professional identity. As such, we both brought in preconceived notions of what might draw people to work with certain populations, and what might be beneficial in the therapy room with clients and discussed these as I was analyzing the



results. Thus, the development of the results is likely in part influenced by our training backgrounds, and the intersection between them.

Also, notably, a large portion of this research project took place during the COVID-19 pandemic. Once I had completed data collection and analysis, we were all transitioned to working from home. My results meeting took place over Zoom, as did all supervisory meetings with Dr. Cummings. This was an adjustment that required flexibility and continuous communication amongst us all. I am grateful to my supervisor, and my committee, for the efforts that were made to ensure that we could still meet and that my dissertation work could still go ahead. I recognize that although I was used to choosing to work from home, it was quite different from being *required* to work from home, particularly in the context of rarely being able to leave my house. I am aware that I was much less motivated and felt less creative when I was working from home during the pandemic. I can only assume that this influenced the writing and ideas that went into this final document.

Further, during this pandemic there has been a significant increase in reports of IPA (Bradbury-Jones & Isham, 2020; Bradley et al., 2020; Campbell, 2020; Taub, 2020; Usher et al. 2020; van Gelder et al., 2020). We have also seen reports of COVID-19-specific methods of abuse, including misinformation used by intimate partners related to the extent of quarantine measures (Gearin & Knight, 2020). This data sparked a lot of additional considerations for me. One, being that these articles predominantly focus on the safety of women and children. Though an incredibly important issue, these articles effectively erased men's experiences of IPA during COVID-19. If men are not reporting abuse during this pandemic, we need to be asking the question of why. Further, with relation to my research project, this pandemic engendered several concerns for my participants. At the time of interviews, none of my dissertation participants were still in a relationship with their abuser. However, the pandemic likely removed a number of social and professional supports that were available to them. Furthermore, a number of participants had shared custody with their ex-partners. Thus, I reflected on how the pandemic might exacerbate disagreements and difficulties in navigating this. In addition, I am curious how the finalized help-seeking model might look different when individuals are social isolating at home with their abuser. It is possible that certain services are no longer available to them, that they do not have privacy to call and seek help, that there might be different thresholds for recognizing severity, amongst other differences.

With regards to service providers, I am cognizant that the process of forming a validating connection likely also looks different during the pandemic. Numerous counsellors have made the transition to telehealth in order to continue to provide services to their clients (Zhou et al., 2020). However, there are recommendations suggesting that clinicians should not begin telehealth services with new clients who they have not met, due to the potential difficulties with developing the therapeutic relationship solely over telehealth (Online Therapy Institute, n.d.). This is particularly salient when working with people who have experienced IPA, for whom research suggests building a trusting relationship is a particularly integral part of therapy (Roddy & Gabriel, 2019). This presents ethical concerns when clinicians are faced with clients who are in crisis or who require immediate services. Furthermore, clinicians will be faced with additional safety and privacy concerns. For example, if the client is living with their abuser who they do not want made aware that they are engaging in counselling. Further, with telehealth if the client's safety is a concern, the therapist is unable to physically be in the room with the client, and there is potential for the client and therapist's telehealth session to become disconnected (e.g., due to technology concerns, or purposefully). As such, counsellors must have a safety plan in place with clients, in case of disconnection during an emergency or concerning situation.

I further had a significant experience with one participant, whereby I was placed in a dual-role situation. This participant disclosed imminent risk for harm to himself during a telephone interview. After a thorough suicide-risk assessment and consultation with my supervisor, I created a safety plan with this participant regarding next-steps. Our discussion resulted in me offering to meet him at the nearest emergency department in order to offer support as he sought help. In this way, the participant was both "seeking help" from myself and was adding an additional help-seeking experience to his story, by seeking help from the emergency department. This was an important experience for me to reflect upon for this dissertation, as I witnessed first-hand this participants' full help-seeking process. Yet, this information was not provided to me during the interview, and thus I had to engage in reflection regarding what information I could ethically include in my dissertation. After consultation with my supervisor, we decided that any information gathered after and including the initial suicide risk assessment should not be included in this project. However, I still had developed a much more personal relationship with this participant, than other participants, after having sat in the Emergency Room with him for over four hours. This meant that if I were to do a follow-up interview with

this participant, it is possible that I would gather different information than if we had not gone through this experience together.

Furthermore, I witnessed first-hand the extreme failure of the health care system to provide this participant help. I saw, in real time, multiple service-providers fail to acknowledge this participants' experience as severe and worthy of immediate help. As such, I was presented with an ethical dilemma, whereby I felt the need to speak with health care staff regarding their failure to provide services to this individual. This consisted of consultation with my research supervisor and gaining consent from my participant to speak with staff. Despite advocating on my participant's behalf, they did not expedite service provisions, despite his desire to leave the hospital due to the lengthy wait time. As such, my participant left the hospital and did not receive the help that he needed. Although he presented with suicidal ideation and not as someone who has experienced IPA, it was still evident that there is a dearth of service available, and that this is an area that needs further advocacy and improvement. As such, this experience re-inspired me as to the necessity of this research and engendered a further desire to work to improve availability and accessibility of services well after this dissertation project is complete.

I should also draw attention to the process of deciding upon verbiage to describe individuals who have experienced IPA. I began this process utilizing the term "victim," and readers might notice that this term is used in most of the ethics and research materials. However, throughout the research journey I was made more aware of the issues taken with this term. This was first brought to my attention by a member of my Indigenous Advisory Committee, who noted that this term is disempowering and can be pathologizing. They told me that using the term victim emphasizes individuals' weaknesses and difficulties, rather than their strengths. When I later consulted the literature, research indicates that people who have experienced traumatic or stressful events echo this idea (Durfee, 2011; Newsom & Myers-Bowman, 2017). The label of victim has been said to carry "negative connotations of being damaged, passive, and powerless" (Best, 1997, p. 13, as cited in Leisenring, 2006), and rather, the term survivor has emerged as an alternative to that of victim (Leisenring, 2006). Leisenring (2006) further cites Barry (1979) who stated that "more than victims, women who have been raped or sexually enslaved are survivors. Surviving is the other side of being a victim. It involves will, action, initiative on the victim's part." (p. 39).

Research specifically with men who have experienced IPA indicates that they often refrain from using the term victim to describe themselves, as they prefer terms that center around their sense of power and control (Durfee, 2011). However, there remains a subset of individuals who believe that the term victim is appropriate for them, and actively discount the validity of utilizing the term survivor to describe all individuals who have had traumatic experiences (Campaomor, 2018). From reviewing this literature, I felt like I developed a much more complex view of the terminology used to describe people's experiences. There is in no way a one-size-fits-all answer to how or if we should ascribe labels to people's experiences. Rather, this appears to be very personal and individually defined.

Through reflecting on this, I believe it best practice to ask individuals what terms they would like to use to describe their experiences, and to respectfully use those. With the exception of the ethics materials (which had already been utilized prior to this decision), I decided to change the language throughout my dissertation to remove the terms victim and survivor. Rather, I decided to predominantly use person-first language (e.g., men who experience IPA), as I believe that this approach respects both sides of the survivor-victim "debate." Last, I included the terms "victim" and "victimization" when I was describing previously conducted research, and/or when the terms were necessary to explain concepts (e.g., when talking about masculinity and perceptions of "victim" statuses).

All attempts were made to present as neutral and non-judgmental as possible throughout the interviews and data analyses. As mentioned, throughout the research process I engaged in personal reflection, memoing, and consultation with my research supervisor regarding these areas of potential bias. These efforts were made in order to identify areas of potentially leading interview responses or data interpretations, and to consider altering these responses in future interviews. However, many of these personal positions and views cannot, nor should not, be fully eliminated given my epistemological position and my belief in the co-construction of knowledge. Thus, these aforementioned areas were at the very least reflected upon throughout the process of this dissertation and are noted as potential influences upon the research process.

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## APPENDIX A: STUDY 1 MATERIALS

### Appendix A.1: Men Screening Checklist/Initial Phone Script

ID \_\_\_\_\_ VOICEMAIL? Y/N \_\_\_\_\_ DATE OF CALL: \_\_\_\_\_

“Thank you for contacting us regarding our study. We’d like to give you a bit more information about the project, answer any questions you might have, and complete some initial screening questions to see if you qualify to participate.”

“The purpose of this study is to understand men’s experiences of abuse in relationships. Specifically, we are looking to understand experiences of abusive relationships with women and consequent help-seeking and help-receiving experiences, if any. So this screening call involves me gathering a bit of information about your experience to determine whether you qualify to participate. This screening call is not being audio or video recorded, and you can decide to stop the conversation at any time if you wish. Everything that we discuss today will be kept completely confidential. However, there are some limits to that confidentiality. Specifically, if you tell us that you are at imminent risk to hurt yourself or someone else, we can break your confidentiality without your permission to keep you safe. If you provide information that leads us to suspect that a child is at current risk of experiencing abuse, we are required to report that information to your local child protective services. Last, if our records are ever subpoenaed by a court of law, we might be required to disclose these.

If you meet our study’s criteria and you are interested in participating, our interviews take approximately 60 to 90 minutes and are conducted by phone. We audio-record the interviews so that we can transcribe them and then analyze them. If you are eligible and choose to participate in this study, you should know that your interview answers are confidential except for those few limitations mentioned above. While participating in an interview you have the right to decline to answer any questions you do not wish to answer.

Do you have any questions?” [Researcher answers any questions]

Do you agree to participate in this screening interview? ☐ Yes ☐ No [Thank the potential participant for their time, and delete the audio recording]

#### Demographic Questions:

“I’d like to start by asking a few quick demographic questions. This allows us to determine whether you qualify to participate, and also can help guide us in doing this research with you in the most respectful way possible. *Can you please tell me your age, gender, and what ethnicity/cultural group you would self-identify as?*

The following information will be gathered, in order to determine whether the identify with their Indigenous heritage:

*We know that some people identify very strongly with their cultural heritage, and some people do not. Could you tell me a bit about what your Indigenous identity means to you?*

- Gather general information

*If information gathered indicates a strong cultural alignment, then we will consult our advisory committee to determine how to go about data collection in a culturally sensitive and appropriate way*

“Now I’d like to ask you a few screening questions to determine if you qualify to participate, okay?” [If potential participant says no, thank them for their interest]

Screening Questions:

- ☐ Have you ever been in a relationship with a woman that you considered to be abusive?  
*(Include dates and timeline – need to determine if they are currently in an abusive relationship, and if not, when their previous abusive relationship ended)*
- ☐ What type of abuse did you experience? (gather general information re: physical, emotional, psychological, financial, etc., to determine if their experience meets “abuse” criteria) *Can go through this list if necessary*

- ☐ Stalking
- ☐ Physical violence (e.g., slapping, hitting)
- ☐ Sexual violence or coercion
- ☐ Controlling behaviours (isolation from family/friends, restricted access to finances)
- ☐ Psychological aggression (e.g., name-calling, humiliation)

- ☐ Have you ever sought help for this experience? (Formal or informal)
- ☐ What type of help?
- ☐ *(If currently in abusive relationship)* Do you feel you are safe in your current relationship situation?

*Refer to appropriate services if necessary:*

Crisis lines:

- <https://suicideprevention.ca/need-help/>
- <http://www.crisisservicescanada.ca/>

Can send them the list of services from the Debriefing Form as well

*If upset:*

- ☐ It seems like talking about this experience is pretty upsetting for you. We don’t want to add any more to that distress or push you to speak about experiences if you don’t feel that you are ready at this time in your life. I just want to check-in, and ask, if you are eligible, are you still interested in participating in this study?

*For everyone:*

- ☐ What general time of day works best to call you?

“Thank you for your interest in our study and answering these questions. I now need to consult with my research supervisor to confirm your eligibility. I will do so and get back to you as soon as possible to follow up.

## APPENDIX A.2

### Study 1: Consent Form (Original – Negative and Non-Negative Cases)

**Project Title:** The Process of Men Seeking Help for Intimate Partner Abuse (IPA)

**Researcher:** Kelsi Toews, Clinical Psychology Graduate Student, Department of Psychology, University of Saskatchewan, (306) 966-6731, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Supervisor:** Jorden Cummings, Ph.D., Department of Psychology, University of Saskatchewan. Jorden Cummings: (306) 966-7147, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Purpose and Procedure:** You have been asked to participate in a study designed to understand men's experiences with intimate partner abuse (IPA). IPA involves coercive or controlling action used to gain power and control over a current or preexisting intimate partner. These incidents can include physical, psychological, emotional, verbal, sexual, financial or economic threat, abuse or violence including social isolation and stalking. We will be asking you about your abuse experience, your thoughts about seeking help, your experience of seeking and receiving help (if any), and what life has been like since. We might ask specifically about your experience with the abuse, but you can disclose as much or as little as you are comfortable with. Specific details of what happened are not required to participate. We will also ask you to provide your age and ethnicity so that the researcher can describe the characteristics of the larger sample. This interview will take approximately 60-90 minutes.

In some instances, we like to contact participants to complete a second interview. Once you finish today, we will ask for your permission to contact you again if needed. You are welcome to decline to be contacted. If you do permit us to contact you again, we will ask you at that time if you still wish to participate in another interview. You are welcome to decline to be interviewed again when the time comes.

All interviews will be conducted over the phone. Your interview will be audio-recorded for later transcription and coding. If you wish, you may request a copy of your interview transcript from the researcher, who can provide an electronic copy or hard copy of the de-identified transcript. Please be aware that not all email servers are secure, and thus there is a possibility of data breach with this method. Transcripts sent over email will be password protected. If you wish to add additional information or context to your transcript after receiving it, you are welcome to contact the researcher to do so. Your data will be combined and analyzed with other participants. If any part of your interview (e.g., a quote of something that you said) is being considered for use in a research product, it will be de-identified so that your identity is not recognizable.

**Potential Benefits:** Although there are no guaranteed benefits of participating, research does show that discussing stressful experience can release distress, and that participants can find it to be a helpful, supportive, and insightful experience. Previous participants in similar studies conducted by our lab reported that telling their story was helpful. It is also hoped that data from this project will inform support and intervention strategies for other men who have experienced IPA.

**Potential Risks:** There are no anticipated risks as a result of participating in this study, although you might feel emotional discussing your experience. Should you feel uncomfortable at any time, you have the right to refuse to answer any questions that we ask or withdraw from this study without penalty. You may request the audio-recorder be switched off at any time, without giving a reason. You can also contact the researcher to discuss your reactions to the study, if you feel distressed later on, at the contact information listed above. However, please note that we will likely not be immediately available, and you might have to wait up to 2 business days for a reply. Thus, if you are emergently distressed, you should go to your nearest emergency room, call the mobile crisis help line (306-757-0127), or call 911. After the interview today you will be provided with the opportunity to discuss your reactions with the researcher, as well as a debriefing form which outlines steps to take if you are upset later on.

**Compensation:** You will not receive compensation for your participation in this study.

**Storage of Data:** Your data will be stored for a minimum of 5 years post-publication or project termination on a password protected computer in a secured office. Your data will be stored using a unique ID number, so as to maintain confidentiality. Consent forms will be stored separately from the data. Your name and email address will be kept on file, in case you agree to being contacted for future interviews. However, this information will never be stored in the same file as your interview and transcript data, and this file will also be password protected. Your name and identifying information will be removed from any interview transcript, and you will be given a pseudonym instead. Your data will be archived and potentially used in future research.

**Confidentiality:** All responses you provide in this study will be kept confidential, with the exception of a few circumstances described below. Any information derived from this research project that personally identifies you will not be disclosed to anyone by the researchers. Interviews will be audio recorded on lab digital voice recorders. Recording devices will be kept in a locked cupboard behind a locked door in our research lab. Audio recordings will be transferred from the devices onto a password protected computer, housed in a locked research laboratory, immediately upon completion of the interview. Once they have been transferred to the computer, they will be deleted from the digital voice recorder. These interviews will be transcribed by the student researcher. When transcribing these interviews, names and other identifying information will be deleted from the transcripts. These transcriptions will be password protected and will be housed on a university computer which is also password protected, and behind a locked research laboratory door. These recordings and transcripts will also be housed on our online lab drive, which is secure and confidentiality (i.e., only the student researcher and Dr. Jorden Cummings have access). Printed copies of the transcripts used for coding purposes will always be kept in the lab and locked in a filing cabinet kept in a locked room. Any quotes taken from the interview for research dissemination will be non-identifiable. Please note that other individuals in our lab who are not associated with the research project will have access to the email address and telephone number provided to you for contacting us. This means that they will have access to recruitment emails, discussion of distress if emailed, and voicemails if left, which might compromise your confidentiality. However, all individuals in our lab have signed confidentiality agreements meaning that they will not share any private or confidential information with anyone outside of our lab. They are also student researchers who understand the incredibly importance of keeping your information safe and confidential. The student researcher (Kelsi Toews) will transcribe the audio recordings.

**Limits to Confidentiality:** There are some situations where confidentiality can be broken **without your permission**. If any of these circumstances arise, we will make every effort to discuss them with you before breaking confidentiality. These instances include:

- a) If you indicate that you are at imminent risk to harm yourself or someone else, we are required to help keep you safe and can intervene to do so. This might require us to waive your confidentiality so that appropriate help can be sought;
- b) If we have reason to suspect that a child is currently being abused, we are obligated to report this information to child protective services and your confidentiality may be waived to do so;
- c) If our records are subpoenaed by a court of law, we might be required to release information.

**Right to Withdraw:** Your participation is voluntary and you can answer/ talk about only those questions that you are comfortable with. You may stop the interview at any time, without explanation or penalty of any sort. You are also able to withdraw your interview data after the interview, until the point that the data from your interview is analyzed (approximately September, 2019). After this time, it might not be possible to withdraw your data. If you withdraw from the research project prior to that point, any data that you have contributed will be destroyed.

**Follow up:** If you have any questions regarding the research project, you are free to contact the researcher, Kelsi Toews, and/or her supervisor, Dr. Jorden Cummings, at the contact information provided above. We also understand that talking and/or thinking about difficult experiences can be hard. If you feel upset at any point in this process, we would like to discuss this with you. You can contact Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>

This research project was approved on ethical grounds by the University of Saskatchewan Research Ethics Boards on April 23, 2019. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (1-888-966-2975 or [ethics.office@usask.ca](mailto:ethics.office@usask.ca)). Results from this study will be available in the Fall of 2021, and you can obtain a copy by contacting Kelsi Toews.

By providing verbal permission, it is understood that you have read and understood the description provided, had an opportunity to ask questions, and that your questions have been answered. You consent to participate in the research project, understanding that you may withdraw your consent at any time. This consent will be audio recorded.



## APPENDIX A.2.1

### Study 1: Consent Form (Indigenous Participants)

**Project Title:** The Process of Men Seeking Help for Intimate Partner Abuse (IPA)

**Researcher:** Kelsi Toews, Clinical Psychology Graduate Student, Department of Psychology, University of Saskatchewan, (306) 966-6731, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Supervisor:** Jorden Cummings, Ph.D., Department of Psychology, University of Saskatchewan. Jorden Cummings: (306) 966-7147, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Purpose and Procedure:** You have been asked to participate in a study designed to understand men's experiences with intimate partner abuse (IPA). IPA involves coercive or controlling action used to gain power and control over a current or preexisting intimate partner. These incidents can include physical, psychological, emotional, verbal, sexual, financial or economic threat, abuse or violence including social isolation and stalking. We will be asking you about your abuse experience, your thoughts about seeking help, your experience of seeking and receiving help (if any), and what life has been like since. We might ask specifically about your experience with the abuse, but you can disclose as much or as little as you are comfortable with. Specific details of what happened are not required to participate. We will also ask you to provide your age and ethnicity so that the researcher can describe the characteristics of the larger sample. This interview will take approximately 60-90 minutes.

In some instances, we like to contact participants to complete a second interview. Once you finish today, we will ask for your permission to contact you again if needed. You are welcome to decline to be contacted. If you do permit us to contact you again, we will ask you at that time if you still wish to participate in another interview. You are welcome to decline to be interviewed again when the time comes.

We have been working with an Indigenous research advisory committee in order to ensure that we conduct research in a culturally appropriate way. Based on their guidance, you will be given the option to choose to participate in the interview over the telephone or in person. Your interview will be audio-recorded for later transcription and coding. If you wish, you may request a copy of your interview transcript from the researcher, who can provide an electronic copy or hard copy of the de-identified transcript. Please be aware that not all email servers are secure, and thus there is a possibility of data breach with this method. Transcripts sent over email will be password protected. If you wish to add additional information or context to your transcript after receiving it, you are welcome to contact the researcher to do so. Your data will be combined and analyzed with other participants. If any part of your interview (e.g., a quote of something that you said) is being considered for use in a research product, it will be de-identified so that your identity is not recognizable.

**Potential Benefits:** Although there are no guaranteed benefits of participating, research does show that discussing stressful experience can release distress, and that participants can find it to be a helpful, supportive, and insightful experience. Previous participants in similar studies conducted by our lab reported that telling their story was helpful. It is also hoped that data from

this project will inform support and intervention strategies for other men who have experienced IPA.

**Potential Risks:** There are no anticipated risks as a result of participating in this study, although you might feel emotional discussing your experience. Should you feel uncomfortable at any time, you have the right to refuse to answer any questions that we ask or withdraw from this study without penalty. You may request the audio-recorder be switched off at any time, without giving a reason. You can also contact the researcher to discuss your reactions to the study, if you feel distressed later on, at the contact information listed above. However, please note that we will likely not be immediately available, and you might have to wait up to 2 business days for a reply. Thus, if you are emergently distressed, you should go to your nearest emergency room, call the mobile crisis help line (306-757-0127), or call 911. After the interview today you will be provided with the opportunity to discuss your reactions with the researcher, as well as a debriefing form which outlines steps to take if you are upset later on.

**Compensation:** You will not receive compensation for your participation in this study.

**Storage of Data:** Your data will be stored for a minimum of 5 years post-publication or project termination on a password protected computer in a secured office. Your data will be stored using a unique ID number, so as to maintain confidentiality. Consent forms will be stored separately from the data. Your name and email address will be kept on file, in case you agree to being contacted for future interviews. However, this information will never be stored in the same file as your interview and transcript data, and this file will also be password protected. Your name and identifying information will be removed from any interview transcript, and you will be given a pseudonym instead. Your data will be archived and potentially used in future research.

**Confidentiality:** All responses you provide in this study will be kept confidential, with the exception of a few circumstances described below. Any information derived from this research project that personally identifies you will not be disclosed to anyone by the researchers. Interviews will be audio recorded on lab digital voice recorders. Recording devices will be kept in a locked cupboard behind a locked door in our research lab. Audio recordings will be transferred from the devices onto a password protected computer, housed in a locked research laboratory, immediately upon completion of the interview. Once they have been transferred to the computer, they will be deleted from the digital voice recorder. These interviews will be transcribed by the student researcher. When transcribing these interviews, names and other identifying information will be deleted from the transcripts. These transcriptions will be password protected and will be housed on a university computer which is also password protected, and behind a locked research laboratory door. These recordings and transcripts will also be housed on our online lab drive, which is secure and confidentiality (i.e., only the student researcher and Dr. Jorden Cummings have access). Printed copies of the transcripts used for coding purposes will always be kept in the lab and locked in a filing cabinet kept in a locked room. Any quotes taken from the interview for research dissemination will be non-identifiable. Please note that other individuals in our lab who are not associated with the research project will have access to the email address and telephone number provided to you for contacting us. This means that they will have access to recruitment emails, discussion of distress if emailed, and voicemails if left, which might compromise your confidentiality. However, all individuals in our lab have signed confidentiality agreements meaning that they will not share any private or

confidential information with anyone outside of our lab. They are also student researchers who understand the incredibly importance of keeping your information safe and confidential. The student researcher (Kelsi Toews) will transcribe the audio recordings.

**Limits to Confidentiality:** There are some situations where confidentiality can be broken **without your permission**. If any of these circumstances arise, we will make every effort to discuss them with you before breaking confidentiality. These instances include:

- a) If you indicate that you are at imminent risk to harm yourself or someone else, we are required to help keep you safe and can intervene to do so. This might require us to waive your confidentiality so that appropriate help can be sought;
- b) If we have reason to suspect that a child is currently being abused, we are obligated to report this information to child protective services and your confidentiality may be waived to do so;
- c) If our records are subpoenaed by a court of law, we might be required to release information.

**Right to Withdraw:** Your participation is voluntary and you can answer/ talk about only those questions that you are comfortable with. You may stop the interview at any time, without explanation or penalty of any sort. You are also able to withdraw your interview data after the interview, until the point that the data from your interview is analyzed (approximately September, 2019). After this time, it might not be possible to withdraw your data. If you withdraw from the research project prior to that point, any data that you have contributed will be destroyed.

**Follow up:** If you have any questions regarding the research project, you are free to contact the researcher, Kelsi Toews, and/or her supervisor, Dr. Jorden Cummings, at the contact information provided above. We also understand that talking and/or thinking about difficult experiences can be hard. If you feel upset at any point in this process, we would like to discuss this with you. You can contact Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>

This research project was approved on ethical grounds by the University of Saskatchewan Research Ethics Boards on April 23, 2019. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (1-888-966-2975 or [ethics.office@usask.ca](mailto:ethics.office@usask.ca)). Results from this study will be available in the Fall of 2021, and you can obtain a copy by contacting Kelsi Toews.

By providing verbal permission, it is understood that you have read and understood the description provided, had an opportunity to ask questions, and that your questions have been answered. You consent to participate in the research project, understanding that you may withdraw your consent at any time. This consent will be audio recorded.

## APPENDIX A.3

### Study 1: Interview Guide (Interviews 1- 4)

“I know you’ve had a negative experience, one with an intimate partner, and you are participating in this study about it. I’d like to let you know that it is entirely up to you how much detail you wish to share with me about the specific experience – you can share details if you wish, but it is also possible to participate in this study without sharing any of the details of what happened.”

“I’d like to start by asking you about your relationship with this individual. I’d like to better understand the context that this experience occurred in. Feel free to start wherever you’d like with this, and to share as much or as little detail as possible, whatever you are comfortable with.”

1. Tell me about the first time it crossed your mind that you might want to get help, in any form, related to this experience.
2. Tell me about going from it crossing your mind to seeking help
3. Tell me about your experience of seeking that help
4. Tell me about the help that you received
5. How have things been since then?

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

#### Debriefing:

*Start debrief with reflection and grounding if necessary.*

“Thanks so much for sharing your story with us. How was it for you to be talking to me in this way?”

## APPENDIX A.4

### Study 1: Interview Guide (Interviews 5 + 6)

“I know you’ve had a negative experience, one with an intimate partner, and you are participating in this study about it. I’d like to let you know that it is entirely up to you how much detail you wish to share with me about the specific experience – you can share details if you wish, but it is also possible to participate in this study without sharing any of the details of what happened.”

“I’d like to start by asking you about your relationship with this individual. I’d like to better understand the context that this experience occurred in. Feel free to start wherever you’d like with this, and to share as much or as little detail as possible, whatever you are comfortable with.”

1. Tell me about the first time it crossed your mind that you might want to get help, in any form, related to this experience.
2. Can you tell me a little bit more about the story of your decision to seek help?
3. Tell me about going from it crossing your mind to seeking help
4. Tell me about your experience of seeking that help
5. Tell me about the help that you received
6. Can you tell me the story of your journey towards realizing that you were in an abusive relationship?
  - a. What led up to this realization?”
  - b. Did anything happen after this realization?”

“How have things been since then?”

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

#### **Debriefing:**

*Start debrief with reflection and grounding if necessary.*

“Thanks so much for sharing your story with us. How was it for you to be talking to me in this way?”

## APPENDIX A.5

### Study 1: Interview Guide (Interviews 7 + 8)

“I know you’ve had a negative experience, one with an intimate partner, and you are participating in this study about it. I’d like to let you know that it is entirely up to you how much detail you wish to share with me about the specific experience – you can share details if you wish, but it is also possible to participate in this study without sharing any of the details of what happened.”

“I’d like to start by asking you about your relationship with this individual. I’d like to better understand the context that this experience occurred in. Feel free to start wherever you’d like with this, and to share as much or as little detail as possible, whatever you are comfortable with.”

1. Tell me about the first time it crossed your mind that what you were experiencing might be abuse
2. Tell me about the first time it crossed your mind that you might want to get help, in any form, related to this experience.
  - a. What was that experience like, of realizing that you might need help?
  - b. What factors did you consider in deciding to seek out help?”
3. Tell me about going from it crossing your mind to seeking help
  - a. What did this process entail?
  - b. Walk me through deciding/why did you ultimately decide to get help?
  - c. What types of help did you consider?
  - d. How did you eventually decide on the type of help?
4. Tell me about your experience of seeking that help
  - a. Was there a point where you were surveying your options?
5. Tell me about the help that you received
6. Did you experience any uncertainty about seeking help?
  - a. Why?
  - b. How did you overcome it? (if they did)
  - c. What would have had to be different in order for you to seek help? (if they did not)
  - d. What were the advantages and disadvantages of seeking help for you?
  - e. Were there times during your relationship or after, where you experienced something distressing and did not seek help? Why?
7. What I have been hearing from participants is that they experience some ambivalence about seeking help – did you have this experience?
8. How have things been since then?

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

#### **Debriefing:**

*Start debrief with reflection and grounding if necessary.*

“Thanks so much for sharing your story with us. How was it for you to be talking to me in this way?”

## Appendix A.6

### Study 1: Interview Guide (Negative Cases)

“I know you’ve had a negative experience, one with an intimate partner, and you are participating in this study about it. I’d like to let you know that it is entirely up to you how much detail you wish to share with me about the specific experience – you can share details if you wish, but it is also possible to participate in this study without sharing any of the details of what happened.”

“I’d like to start by asking you about your relationship with this individual. I’d like to better understand the context that this experience occurred in. Feel free to start wherever you’d like with this, and to share as much or as little detail as possible, whatever you are comfortable with.”

1. Tell me about the first time it crossed your mind that what you were experiencing might be abuse
2. So, with abusive relationships, sometimes people seek help, and sometimes people don’t. Neither one is necessarily the correct answer. I know you noted in the interview that you decided not to seek professional help – I was wondering if you could walk me through that decision?
3. Was there ever a point where you thought that you might need professional help for what you were experiencing? Tell me the story of this
  - a. What was that experience like, of realizing that you might need help?
  - b. What factors did you consider during this process?
  - c. Was there a point where you were surveying your options?
4. Did you experience any uncertainty about seeking help?
  - a. What was this uncertainty about?
  - b. What would have had to be different in order for you to seek help? (if they did not)
  - c. What were the advantages and disadvantages of seeking help for you?
5. Did you seek out any non-professional forms of help (e.g., internet, friends, family)
  - a. Tell me the story of this experience
  - b. What factors did you consider during this decision?
  - c. Tell me about the decision to utilize [non-professional form of help] as opposed to a professional
6. What I have been hearing from participants is that they experience some ambivalence about seeking help – did you have this experience?
7. How have things been since then?

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

#### **Debriefing:**

*Start debrief with reflection and grounding if necessary.*

“Thanks so much for sharing your story with us. How was it for you to be talking to me in this way?”

## **APPENDIX A.7**

### **Study 1: Debriefing Form**

#### **DEBRIEFING – The Process of Men Help-Seeking for Intimate Partner Abuse**

This study examined the process that individuals go through when considering seeking help for experiences of intimate partner abuse (IPA). Thank you so much for sharing your story with us.

Research suggests that men experience IPA at high rates, and that this abuse can have multiple, deleterious effects on men's physical and mental health. However, men are often reluctant to seek help for this abuse. This is shown to be due to a variety of factors, such as concerns about masculinity, lack of available resources, and negative help-seeking experiences. These factors can have a variety of negative implications, such as staying in the abusive situation longer and amplified mental and physical health effects. However, much previous research on men and IPA has focused on abuse experiences and help-seeking experiences, but has not thoroughly investigated the journey from abuse, to help-seeking, to help-receiving, to after-effects. For this reason, the aim of this study was to develop an understanding of this journey. Understanding this process can help providers understand some of the barriers to help-seeking for men, to develop more appropriate services, and might provide insight into what factors might place men at risk of rejecting help, and/or of not attaining healing from abuse.

The researcher will transcribe your audio-recorded interview. We will then be examining transcripts of interviews for themes and common experiences across participants. In any research product, your identity will be disguised so that your confidentiality is protected. Sometimes, we might find it helpful to contact participants for a second interview. If you provide permission for us to contact you, you are still able to decline to participate in a second interview when the time comes.

If you have any comments or questions regarding the conduct of this research or your rights as a research participant, you may contact the researcher Kelsi Toews, 306-966-6731 her supervisor Dr. Jorden Cummings at 306-966-7147, Dr. Gordon Sarty (Head of the Psychology Department at the University of Saskatchewan) at 306-966-2321, and/or the Ethics Office at 306-966-2084. You can also send us an email at [trauma.research@usask.ca](mailto:trauma.research@usask.ca). Furthermore, if you would like additional information about the study and its results, please do not hesitate to contact me at the email address above. We anticipate that final results regarding this study will be available in the Fall of 2021.

We understand that talking about trauma can be a difficult experience. If you feel upset following your interview, we would like to discuss this with you. If you have a negative emotional response later, you may contact the researcher, Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>. There is also a list of supports available to you, listed below.

Thank you again for participating in this research project, and for sharing your story with us,  
Kelsi Toews



**Support Services:**

1. Comprehensive list of abuse help-lines across Saskatchewan:  
<https://pathssk.org/resources/abuse-help-lines/>
2. Saskatoon Crisis Intervention Services: (306) 933-6200 (24 hour)
3. Mobile Crisis Helpline call: (306) 757-0127
4. Rural Saskatchewan can call the Farm Stress Line: 1 (800) 667-4442
5. First Nations and Inuit Hope for Wellness Toll-free Help Line: 1 (855) 242-3310
  - This is a National toll-free number that provides immediate, culturally competent, telephone crisis intervention counselling support for First Nations and Inuit, 24 hours a day, seven days a week. Counsellors can also work with callers to identify follow-up services they can access. Counselling is available in English and French and, upon request, in Cree, Ojibway, and Inuktitut.
6. Saskatchewan Towards Offering Partnership Solutions to Violence
  - This website offers contact information for support service which they believe will be most relevant for specific demographics. It is important to note that certain programs might not be best suited to your needs, despite them being included on the list. We encourage you to explore a variety of options
    - i. Indigenous: <http://www.stopstoviolence.com/aboriginal-people>
    - ii. Men: <http://www.stopstoviolence.com/men>
7. Saskatchewan College of Psychologists Directory: [http://www.skcp.ca/?page\\_id=53](http://www.skcp.ca/?page_id=53)
8. Mental Health Therapists approved to provide counselling under Non-Insured Health Benefits in Saskatchewan: <http://www.fsin.com/wp-content/uploads/2017/09/MH-Therapist-List.pdf>
9. Provincial University-Student Only Services:
  - U of S Student Wellness Centre offers mental health assessment, consulting and counselling
    - i. T: 1 (306) 966-5768
    - ii. E: [student.wellness@usask.ca](mailto:student.wellness@usask.ca)
  - U of S Aboriginal Students' Centre offers Cultural programming includes Elders Services and Ceremonies:
    - i. T: 1 (306) 966-5083
    - ii. E: [asc@usask.ca](mailto:asc@usask.ca)
  - U of R Counselling Services
    - i. T: (306) 585-4491
    - ii. W: <https://www.uregina.ca/student/counselling/>
  - U of R Aboriginal Student centre offers programming and services
    - i. T: (306) 337-3153

E: [ASCentre@uregina.ca](mailto:ASCentre@uregina.ca)

## APPENDIX A.8

### Study 1: Recruitment Materials (Template for all recruitment activities)

#### Department of Psychology University of Saskatchewan

ARE YOU A HETEROSEXUAL MAN WHO HAS EXPERIENCED  
ABUSE FROM A FEMALE PARTNER?

**This might include stalking, physical violence (e.g., slapping, hitting), sexual violence or coercion, controlling behaviours (isolation from family/friends, restricted access to finances), or psychological aggression (e.g., name-calling, humiliation)**

If these experiences are familiar to you, you might be eligible to participate in this research study. As a participant in this study, you would be asked to participate in an interview, where you would describe your experience

Your participation would involve a telephone interview, lasting approximately 1 – 1.5 hours

For more information, or to volunteer for this study,  
please contact:

Kelsi Toews (Clinical Psychology Graduate Student)  
at [trauma.research@usask.ca](mailto:trauma.research@usask.ca) or at (306) 966-6731. This study is  
being supervised by Dr. Jorden Cummings  
([Jorden.cummings@usask.ca](mailto:Jorden.cummings@usask.ca), 306-966-7147).

If interested, you will be asked to participate in a short screening interview in order to determine your eligibility for this study. Due to the potentially sensitive nature of this research, we recommend that you do not participate in this project if you believe that it will be upsetting to you.

**This study has been reviewed by, and received approval  
through, the Behaviour Research Ethics Board, BEH#766, University of  
Saskatchewan.**



UNIVERSITY OF  
SASKATCHEWAN

**usask.ca**

## APPENDIX B: STUDY 2 MATERIALS

### Appendix B.1: Service Providers Screening Checklist/Initial Phone Script

ID #: \_\_\_\_\_ PHONE #: \_\_\_\_\_ VOICEMAIL? Y/N DATE OF CALL: \_\_\_\_\_

“Thank you for contacting us regarding our study. We’d like to give you a bit more information about the project, answer any questions you might have, and complete some initial screening questions to see if you qualify to participate.”

“The purpose of this study is to understand service providers’ journeys to provide services to victims of IPA. In particular, we are looking to understand how different service providers come to provide services to male victims of intimate partner abuse.”

“We are collecting stories about this experience from services providers who provide services to victims. These interviews take approximately 60 to 90 minutes and are conducted by phone. We audio-record the interviews so that we can transcribe them and then analyze them. If you are eligible and choose to participate in this study, you should know that your interview answers are confidential except for a few limitations. If you tell us that you are at imminent risk to hurt yourself or someone else, we can break your confidentiality without your permission to keep you safe. If you provide information that leads us to suspect that a child is at current risk of experiencing abuse, we are required to report that information to your local child protective services. Last, if our records are ever subpoenaed by a court of law, we might be required to disclose these. While participating in an interview you have the right to decline to answer any questions you do not wish to answer.”

Do you have any questions?” [Researcher answers any questions]

“Are you interested in participating in the study? If so, I’d like to ask you a few screening questions to determine if you qualify to participate.”

[If potential participant says no, thank them for their interest]

#### Screener Questions:

- ☐ What is your current occupation?
- ☐ Do you provide therapeutic services as part of your job? (i.e., counselling)
- ☐ Do you provide these services to victims of intimate partner abuse?
- ☐ Do you currently, or have you ever, provided services to men who have experienced abuse from a female partner?
- ☐ What general time of day works best to call you?

“Thank you for your interest in our study and answering these questions. I now need to consult with my research supervisor to confirm your eligibility. I will do so and get back to you as soon as possible to follow up.”

## APPENDIX B.2

### Study 2: Consent Form (Original)

**Project Title:** The Process of Providing Help to Men Who Have Experienced Intimate Partner Abuse

**Researcher:** Kelsi Toews, Clinical Psychology Graduate Student, Department of Psychology, University of Saskatchewan, (306) 966-6731, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Supervisor:** Jorden Cummings, Ph.D., Department of Psychology, University of Saskatchewan. Jorden Cummings: (306) 966-7147, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Purpose and Procedure:** You have been asked to participate in a study about working with men who have experienced intimate partner abuse (IPA), either your views as someone who has not worked with this population or your experiences if you have. IPA involves coercive or controlling action used to gain power and control over a current or preexisting intimate partner. These incidents can include physical, psychological, emotional, verbal, sexual, financial or economic threat, abuse or violence including social isolation and stalking. We will be asking you about your career journey, your experiences (if any) with IPA victims, both personal and professional, your opinions regarding different types of IPA victims, and suggestions for going forward in working with this population. We will also ask you to provide your age, gender, and ethnicity so that the researcher can describe the characteristics of the larger sample. This interview will take approximately 60-90 minutes.

In some instances, we like to contact participants to complete a second interview. Once you finish today, we might ask for your permission to contact you again. You are welcome to decline to be contacted. If you do permit us to contact you again, we will ask you at that time if you still wish to participate in another interview. You are welcome to decline to be interviewed again when the time comes.

All interviews will be conducted over the phone. Your interview will be audio-recorded for later transcription and coding. If you wish, you may request a copy of your interview transcript from the researcher, who can provide an electronic copy or hard copy of the de-identified transcript. Please be aware that not all email servers are secure, and thus there is a possibility of data breach with this method. Transcripts sent over email will be password protected. If you wish to add additional information or context to your transcript after receiving it, you are welcome to contact the researcher to do so. Your data will be combined and analyzed with other participants. If any part of your interview (e.g., a quote of something that you said) is being considered for use in a research product, it will be de-identified so that your identity is not recognizable.

**Potential Benefits:** There are no guaranteed benefits of participating. However, research does show that discussing stressful experience can release distress, and that participants can find it to be a helpful, supportive, and insightful experience. Previous participants in similar studies conducted by our lab have reported that telling their story was helpful. Thus, if stress is a component of your story, this might be beneficial for you. It is important to note, however, that you might not gain any direct benefit from your participation. It is hoped that data from this

project will ultimately inform training and improve service provisions to men who have experienced IPA.

**Potential Risks:** There are no anticipated risks as a result of participating in this study, although you might feel emotional discussing your experience. Should you feel uncomfortable at any time, you have the right to refuse to answer any questions that we ask or withdraw from this study without penalty. You may request the audio-recorder be switched off at any time, without giving a reason. You can also contact the researcher to discuss your reactions to the study, if you feel distressed later on, at the contact information listed above. After the interview today, you will be provided with the opportunity to discuss your reactions with the researcher, as well as a debriefing form which outlines steps to take if you are upset later on.

**Compensation:** You will not receive compensation for your participation in this study.

**Storage of Data:** Your data will be stored for a minimum of 5 years post-publication or project termination, on a password protected computer in a secured office. Your data will be stored using a unique ID number, so as to maintain confidentiality. Consent forms will be stored separately from the data. Your name and email address will be kept on file, in case you agree to being contacted for future interviews. However, this information will never be stored in the same file as your interview and transcript data, and this file will also be password protected. Your name and identifying information will be removed from any interview transcript, and you will be given a pseudonym instead. Your data will be archived indefinitely, and potentially used in future research.

**Confidentiality:** All responses you provide in this study will be kept confidential, with the exception of a few circumstances described below. The student researcher will transcribe the recording of the interview. Any information derived from this research project that personally identifies you will not be disclosed to any one by the researchers. If we consider quoting your information in any research products, we will not include any identifying information, and will create a pseudonym to be used in place of your name.

**Limits to Confidentiality:** There are some situations where confidentiality can be broken **without your permission**. If any of these circumstances arise, we will make every effort to discuss them with you before breaking confidentiality. These instances include:

- a) If you indicate that you are at imminent risk to harm yourself or someone else, we are required to help keep you safe and can intervene to do so. This might require us to waive your confidentiality so that appropriate help can be sought;
- b) If we have reason to suspect that a child is currently being abused, we are obligated to report this information to child protective services and your confidentiality may be waived to do so;
- c) If our records are subpoenaed by a court of law, we might be required to release information

**Right to Withdraw:** Your participation is voluntary, and you can discuss only those questions that you are comfortable with. You may stop the interview at any time, without explanation or penalty of any sort. You can also withdraw your interview data after the interview, until the point that the data from your interview is analyzed (approximately September, 2019). After this time,

it might not be possible to withdraw your data. If you withdraw from the research project prior to that point, any data you have contributed will be destroyed.

**Follow Up:** If you have questions regarding the research project, you are free to contact the researcher, Kelsi Toews, and/or her supervisor, Dr. Jorden Cummings, at the contact information provided above. We also understand that talking and/or thinking about life experiences, specifically providing services to victims, can be difficult. If you feel upset at any point during this process, we would like to discuss this with you. You may contact Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>. The national Canadian Crisis Helpline number is: 1-833-456-4566, or you can text 45645.

This research project was approved on ethical grounds by the University of Saskatchewan Research Ethics Boards on January 31<sup>st</sup>, 2019. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (1-888-966-2975 or [ethics.office@usask.ca](mailto:ethics.office@usask.ca)). Results from this study will be available in the Fall of 2021, and you can obtain a copy by contacting Kelsi Toews.

By providing verbal consent, it is understood that you have read and understood the form provided, had an opportunity to ask questions, and your questions were answered. You consent to participate in the research project, understanding that you may withdraw your consent at any time. This consent is audio recorded, and the researcher will complete the information below, to further document this consent.

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*Name of Participant*

---

*Researcher's Signature*

---

*Date*

## APPENDIX B.2.1

### Study 2: Consent Form (Negative Case)

**Project Title:** The Process of Providing Help to Men Who Have Experienced Intimate Partner Abuse

**Researcher:** Kelsi Toews, Clinical Psychology Graduate Student, Department of Psychology, University of Saskatchewan, (306) 966-6731, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Supervisor:** Jorden Cummings, Ph.D., Department of Psychology, University of Saskatchewan. Jorden Cummings: (306) 966-7147, [trauma.research@usask.ca](mailto:trauma.research@usask.ca)

**Purpose and Procedure:** You have been asked to participate in a study about working with men who have experienced intimate partner abuse (IPA). In order to fully understand this phenomenon, we would like to speak with other individuals who work with populations who have historically experienced stigmatization from society and service providers alike. We will be asking you about your career journey, your experiences with stigmatized populations, both personal and professional, and suggestions for going forward in working with this population and other stigmatized populations. We will also ask you to provide your age, gender, and ethnicity so that the researcher can describe the characteristics of the larger sample. This interview will take approximately 60-90 minutes.

In some instances, we like to contact participants to complete a second interview. Once you finish today, we might ask for your permission to contact you again. You are welcome to decline to be contacted. If you do permit us to contact you again, we will ask you at that time if you still wish to participate in another interview. You are welcome to decline to be interviewed again when the time comes.

All interviews will be conducted over the phone. Your interview will be audio-recorded for later transcription and coding. If you wish, you may request a copy of your interview transcript from the researcher, who can provide an electronic copy or hard copy of the de-identified transcript. Please be aware that not all email servers are secure, and thus there is a possibility of data breach with this method. Transcripts sent over email will be password protected. If you wish to add additional information or context to your transcript after receiving it, you are welcome to contact the researcher to do so. Your data will be combined and analyzed with other participants. If any part of your interview (e.g., a quote of something that you said) is being considered for use in a research product, it will be de-identified so that your identity is not recognizable.

**Potential Benefits:** There are no guaranteed benefits of participating. However, research does show that discussing stressful experience can release distress, and that participants can find it to be a helpful, supportive, and insightful experience. Previous participants in similar studies conducted by our lab have reported that telling their story was helpful. Thus, if stress is a component of your story, this might be beneficial for you. It is important to note, however, that you might not gain any direct benefit from your participation. It is hoped that data from this project will ultimately inform training and improve service provisions to men who have experienced IPA.

**Potential Risks:** There are no anticipated risks as a result of participating in this study, although you might feel emotional discussing your experience. Should you feel uncomfortable at any time, you have the right to refuse to answer any questions that we ask or withdraw from this study without penalty. You may request the audio-recorder be switched off at any time, without giving a reason. You can also contact the researcher to discuss your reactions to the study, if you feel distressed later on, at the contact information listed above. After the interview today, you will be provided with the opportunity to discuss your reactions with the researcher, as well as a debriefing form which outlines steps to take if you are upset later on.

**Compensation:** You will not receive compensation for your participation in this study.

**Storage of Data:** Your data will be stored for a minimum of 5 years post-publication or project termination, on a password protected computer in a secured office. Your data will be stored using a unique ID number, so as to maintain confidentiality. Consent forms will be stored separately from the data. Your name and email address will be kept on file, in case you agree to being contacted for future interviews. However, this information will never be stored in the same file as your interview and transcript data, and this file will also be password protected. Your name and identifying information will be removed from any interview transcript, and you will be given a pseudonym instead. Your data will be archived indefinitely, and potentially used in future research.

**Confidentiality:** All responses you provide in this study will be kept confidential, with the exception of a few circumstances described below. The student researcher will transcribe the recording of the interview. Any information derived from this research project that personally identifies you will not be disclosed to any one by the researchers. If we consider quoting your information in any research products, we will not include any identifying information, and will create a pseudonym to be used in place of your name.

**Limits to Confidentiality:** There are some situations where confidentiality can be broken **without your permission**. If any of these circumstances arise, we will make every effort to discuss them with you before breaking confidentiality. These instances include:

- a) If you indicate that you are at imminent risk to harm yourself or someone else, we are required to help keep you safe and can intervene to do so. This might require us to waive your confidentiality so that appropriate help can be sought;
- b) If we have reason to suspect that a child is currently being abused, we are obligated to report this information to child protective services and your confidentiality may be waived to do so;
- c) If our records are subpoenaed by a court of law, we might be required to release information

**Right to Withdraw:** Your participation is voluntary, and you can discuss only those questions that you are comfortable with. You may stop the interview at any time, without explanation or penalty of any sort. You can also withdraw your interview data after the interview, until the point that the data from your interview is analyzed (approximately September, 2019). After this time, it might not be possible to withdraw your data. If you withdraw from the research project prior to that point, any data you have contributed will be destroyed.



**Follow Up:** If you have questions regarding the research project, you are free to contact the researcher, Kelsi Toews, and/or her supervisor, Dr. Jorden Cummings, at the contact information provided above. We also understand that talking and/or thinking about life experiences, specifically providing services to victims, can be difficult. If you feel upset at any point during this process, we would like to discuss this with you. You may contact Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>. The national Canadian Crisis Helpline number is: 1-833-456-4566, or you can text 45645.

This research project was approved on ethical grounds by the University of Saskatchewan Research Ethics Boards on January 31<sup>st</sup>, 2019. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (1-888-966-2975 or [ethics.office@usask.ca](mailto:ethics.office@usask.ca)). Results from this study will be available in the Fall of 2021, and you can obtain a copy by contacting Kelsi Toews.

By providing verbal consent, it is understood that you have read and understood the form provided, had an opportunity to ask questions, and your questions were answered. You consent to participate in the research project, understanding that you may withdraw your consent at any time. This consent is audio recorded, and the researcher will complete the information below, to further document this consent.

## APPENDIX B.3

### Study 2: Interview Guide (Interviews 1-3)

“I know that you have had experience working with people who have experienced IPA, and you are participating in this study in relation to that. I’d like to start out by asking about how you came to work in the position you are currently in”

1. Tell me about how you came to work with men who’ve experienced IPA
2. Tell me about your experience (s) working with men who’ve experienced IPA
3. The research shows that some people who work with this population have negative attitudes (e.g...). What do you think about that?
4. Do you feel that attitudes and perceptions that others hold might influence how they provide services to these men?
5. Do you feel like you hold any of these attitudes?
  - a. Have you found that these attitudes influence how you work with men who’ve experienced IPA?
6. Do you feel like your attitudes have changed since working with this population?
7. Do you have any recommendations for encouraging better service provisions to this population?

#### Demographic Questions:

“I’d like to start to wrap up by making sure I understand a few details about your situation”

*Clarify their degree type, years of practice, and employment situation*

“I’d also like to ask a few quick demographic questions. This allows us to describe the overall sample of participants in any research outputs. Can you please give me your age, gender, and what ethnicity you would self-identify as?”

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

## APPENDIX B.4

### Study 2: Interview Guide (Interviews 4-6)

“I know that you have had experience working with people who have experienced IPA, and you are participating in this study in relation to that. I’d like to start out by asking about how you came to work in the position you are currently in”

1. Tell me about how you came to work with men who’ve experienced IPA
2. Tell me about your experience (s) working with men who’ve experienced IPA
3. Do you remember the first man who experienced IPA that you worked with? Tell me about that experience.
4. Are there things that you do differently when working with this population?
  - a. “Why?”
5. Can you tell me about how you came to this place where you work differently with this population?
6. Tell me about why you are choosing/chose to work with this population
7. The research shows that some people who work with this population have negative attitudes (e.g...). What do you think about that?
8. Do you feel that attitudes and perceptions that others hold might influence how they provide services to these men?
9. Do you feel like you hold any of these attitudes?
  - a. Have you found that these attitudes influence how you work with men who’ve experienced IPA?
10. Do you feel like your attitudes have changed since working with this population?
11. Do you have any recommendations for encouraging better service provisions to this population?

#### Demographic Questions:

“I’d like to start to wrap up by making sure I understand a few details about your situation”

*Clarify their degree type, years of practice, and employment situation*

“I’d also like to ask a few quick demographic questions. This allows us to describe the overall sample of participants in any research outputs. Can you please give me your age, gender, and what ethnicity you would self-identify as?”

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

## APPENDIX B.5

### Study 2: Interview Guide (Negative Cases)

“I know that you have had experience working with [stigmatized population], and you are participating in this study in relation to that. I’d like to start out by asking about how you came to work in the position you are currently in”

1. Tell me about how you came to work with [stigmatized population]
2. Tell me about your experience (s) working with [stigmatized population]
3. Are there things that you do differently when working with this population?
  - a. “Why?”
4. Can you tell me about how you came to this place where you work differently with this population?
5. Tell me about why you are choosing/chose to work with this population
6. The research shows that some people who work with this population have negative attitudes (e.g...). What do you think about that?
7. Do you feel that attitudes and perceptions that others hold might influence how they provide services to [stigmatized population]?
8. Do you feel like you hold any of these attitudes?
  - a. Have you found that these attitudes influence how you work with [stigmatized population]
9. Do you feel like your attitudes have changed since working with this population?”
10. Do you have any recommendations for encouraging better service provisions to this population?

#### Demographic Questions:

“I’d like to start to wrap up by making sure I understand a few details about your situation”

*Clarify their degree type, years of practice, and employment situation*

“I’d also like to ask a few quick demographic questions. This allows us to describe the overall sample of participants in any research outputs. Can you please give me your age, gender, and what ethnicity you would self-identify as?”

#### Last Question:

“Is there anything we haven’t touched upon that you think would be relevant for me to know?”

## APPENDIX B.6

### Debriefing Form (Original)

#### **DEBRIEFING – The Process of Providing Help to Men Who Have Experienced Intimate Partner Abuse (IPA)**

This study examined the process you went through to understand and provide services to victims of IPA. Thank you so much for sharing your story with us.

Research suggests that men are hesitant to seek help for IPA. A significant factor in this hesitance is the self-reported responses that they receive from service providers when they do seek help, such as ridicule, being refused services, and being wrongfully blamed/arrested for the abuse. However, research on service providers' perceptions is mixed, with some appearing to display malicious behaviours towards these victims, some mixed perceptions, and some appearing to provide unwavering support and helpful services. What is missing from this research is an understanding of the discrepancies in service providers' opinions of these men. For this reason, the aim of this study was to understand the process that service providers go through to provide services to men who have experienced IPA. Specifically, we are looking at different factors throughout a service providers' journey which might influence their career choice, how they conceptualize men who have experienced IPA, and how they come to provide services to these victims. In order to understand this process fully, we wanted to talk to people who both have and have not worked with men who have been victims of IPA.

The researcher will transcribe your audio-recorded interview. We will then be examining transcripts of interviews for themes and common experiences across participants. In any research product, your identity will be disguised so that your confidentiality is protected. Sometimes, we might find it helpful to contact participants for a second interview. If you provide permission for us to contact you, you are still able to decline to participate in a second interview when the time comes.

If you have any comments or questions regarding the conduct of this research or your rights as a research participant, you may contact the researcher Kelsi Toews, 306-966-6731 her supervisor Dr. Jorden Cummings at 306-966-7147, Dr. Gordon Sarty (Head of the Psychology Department at the University of Saskatchewan) at 306-966-2321, and/or the Ethics Office at 306-966-2084. You can also send us an email at [trauma.research@usask.ca](mailto:trauma.research@usask.ca). Furthermore, if you would like additional information about the study and its results, please do not hesitate to contact me at the email address above. We anticipate that final results regarding this study will be available in the Fall of 2021.

We understand that talking about life experiences, specifically providing services to victims, can be difficult. If you feel upset following your interview, we would like to discuss this with you. If you have a negative emotional response later, you may contact the researcher, Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>. You can also call the national Canadian Crisis Helpline number, which is: 1-833-456-4566, or you can text 45645.

Thank you again for participating in this research project, and for sharing your story with us

## APPENDIX B.6.1

### Debriefing Form (Negative Case)

#### **DEBRIEFING – The Process of Providing Help to Men Who Have Experienced Intimate Partner Abuse (IPA)**

This study examined the process you went through to understand and provide services to individuals who might experience stigmatization from service providers. Thank you so much for sharing your story with us.

Research suggests that men are hesitant to seek help for IPA. A significant factor in this hesitance is the self-reported responses that they receive from service providers when they do seek help, such as ridicule, being refused services, and being wrongfully blamed/arrested for the abuse. However, research on service providers' perceptions is mixed, with some appearing to display malicious behaviours towards these victims, some mixed perceptions, and some appearing to provide unwavering support and helpful services. What is missing from this research is an understanding of the discrepancies in service providers' opinions of these men. For this reason, the aim of this study was to understand the process that service providers go through to provide services to men who have experienced IPA. Specifically, we are looking at different factors throughout a service providers' journey which might influence their career choice, how they conceptualize men who have experienced IPA, and how they come to provide services to these victims. In order to understand this process fully, we wanted to talk to people who both have and have not worked with men who have been victims of IPA, as well as those who work with other stigmatized populations.

The researcher will transcribe your audio-recorded interview. We will then be examining transcripts of interviews for themes and common experiences across participants. In any research product, your identity will be disguised so that your confidentiality is protected. Sometimes, we find it helpful to contact participants for a second interview. If you provide permission for us to contact you, you are able to decline to participate in a second interview when the time comes.

If you have any comments or questions regarding the conduct of this research or your rights as a research participant, you may contact the researcher Kelsi Toews, 306-966-6731 her supervisor Dr. Jorden Cummings at 306-966-7147, Dr. Gordon Sarty (Head of the Psychology Department at the University of Saskatchewan) at 306-966-2321, and/or the Ethics Office at 306-966-2084. You can also send us an email at [trauma.research@usask.ca](mailto:trauma.research@usask.ca). Furthermore, if you would like additional information about the study and its results, please do not hesitate to contact me at the email address above. We anticipate that final results regarding this study will be available in the Fall of 2021.

We understand that talking about life experiences, specifically providing services to victims, can be difficult. If you feel upset following your interview, we would like to discuss this with you. If you have a negative emotional response later, you may contact the researcher, Kelsi Toews or her supervisor Dr. Jorden Cummings, at the number listed above to discuss this reaction. Please note that they might not receive your voicemail or be able to return your call immediately, and so you should not contact them if you have an emergency or are so distressed you are worried about your imminent safety. If you are so distressed that you are unsafe, please go to your nearest emergency room. You can also find crisis lines nearest you using these links: <https://suicideprevention.ca/need-help/>, and/or <http://www.crisisservicescanada.ca/>. You can also call the national Canadian Crisis Helpline number: 1-833-456-4566, or you can text 45645. Thank you again for participating in this research project, and for sharing your story with us.

## APPENDIX B.7

### Study 2: Recruitment Materials (Template for all recruitment activities)

#### Department of Psychology University of Saskatchewan

##### DO YOU WORK WITH VICTIMS OF INTIMATE PARTNER ABUSE?

As a participant in this study, you would be asked to participate in an interview, where you would describe your experience working with this population

Your participation would involve a telephone interview, lasting approximately 1 – 2 hours

For more information, or to volunteer for this study, please contact:

Kelsi Toews (Clinical Psychology Graduate Student)  
at [trauma.research@usask.ca](mailto:trauma.research@usask.ca) or at (306) 966-6731. This study is  
being supervised by Dr. Jorden Cummings  
([Jorden.cummings@usask.ca](mailto:Jorden.cummings@usask.ca), 306-966-7147).

If interested, you will be asked to participate in a short screening interview in order to determine your eligibility for this study

**This study has been reviewed by, and received approval through, the Research Ethics Office, University of Saskatchewan. (BEH# 623)**



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## **APPENDIX B.7.1**

### **Example Recruitment Material for Emailing Negative Cases**

Hello,

My name is Kelsi Toews, and I am a Ph.D. student in the clinical psychology program at the U of S. I'm currently working on my dissertation, which is looking at the personal journey of service providers (i.e., counsellors) who provide services to men who have been in abusive relationships. Basically, this population of men seem to experience quite a bit of stigma from service providers, so I am curious how certain professionals get to this place where they are willing to provide services.

As part of my study, I'm also hoping to talk to service providers who work with other stigmatized populations. I know within the [stigmatized population] community there are numerous stories of negative experiences with therapists and other service providers, and so I am curious if my theory with service providers who help men, might also be applicable to service providers who work with individuals in the [stigmatized population] community, or if there might be some important differences. All that to say, I noticed there are individuals who provide therapy at [location], and I was wondering if you might be willing to pass along this email to see if anyone is interested in participating!

Participation would involve an interview over the phone, which is approximately 60-90 minutes long. If anyone has questions, or is interested in participating, they can contact me at [trauma.research@usask.ca](mailto:trauma.research@usask.ca).

Thanks so much for your time,  
Kelsi